Preliminary Draft
5/30/07

California Grant Application and Annual Report for the Maternal and Child Health Services Title V Block Grant Program

FFY 2007-2008
(October 1, 2007 – September 30, 2008)

Maternal Child and Adolescent Health / Office of Family Planning Branch
Children's Medical Services Branch
Primary Care and Family Health Division
Department of Health Services
State of California

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Note: The Title V Report and Application is submitted annually in a format that reports activities for a five-year cycle. Updates after the first year are identified with the year in brackets. For this year's report cycle, program information not enclosed in brackets applies to information submitted for FY 2005-2006; information enclosed in /2007/ brackets applies to FY 2006-2007; information enclosed in /2008/ brackets applies to FY 2007-2008.

III. STATE OVERVIEW

A. OVERVIEW

Demographics

/2008/ California is the most populous of all US states, with 37.2 million residents in 2006, an increase of 444,000 over the previous year. One in every eight of the nation's residents lives in California. The state's population has increased annually since 1940, but the rate of increase has slowed each year since 2000, from 2.0 percent in 2000-2001 to 1.2 percent in 2005-2006. [1] California is the third largest state in terms of land area and is more than twice the size of 35 other states. [2] //2008//

The population increase is the result of the natural increase (the difference between the number of births and deaths), which accounts for a little over half of the total population increase, plus net migration to the state. Foreign immigration to the state far exceeded domestic migration for the period 2000-2005, with net foreign immigration totaling 1,165,624 and net domestic migration totaling 220,165. [3]

California residents are younger on average than the nation as a whole. The median age for the state in 2004 was 34, which is significantly lower than the median age in the US of 36. [4]

In 2003, there were almost 7.6 million women of childbearing age (15-44) in California. Women of childbearing age represent 22 percent of the state's total population. The 10.2 million children under age 19 account for 29 percent of the population, including 2.5 million under the age of 5 (7 percent), and over 500,000 under one year (1.5 percent). [5] Nationally, children ages 19 and under make up 28 percent of the population, and those under 5 make up 7 percent. [6] Between 2003 and 2009, the female teen population (ages 15-19) in California is projected to increase by 14 percent, and the Hispanic teen female population is projected to increase by 28 percent. [7]

Although the overall teen birth rate has declined steadily since 1991 (from 71 in 1991 to less than 38 in 2004), the decline among Hispanic teens has been slower, and Hispanics are disproportionately represented in the number of California's teen births. [8] Hispanics accounted for 71 percent of teen births in 2004 [9], while only accounting for 42 percent of the total teen population (age 15-19). [10]

Diversity

In addition to its overall population expansion, California continued to experience growth in its ethnic diversity. The fastest growing group is Hispanics. Hispanics, as a proportion of the state population, increased from 26 percent in 1990 to 32 percent in 2000. [11] By the year 2050 the percentage of Hispanics is projected to reach 54 percent, making it the majority ethnic group in the state, as well as the majority ethnic group for twenty counties. [12] In 2000, Whites comprised 47 percent of California's population, followed by Hispanics (32 percent), Asian/Pacific Islanders (12 percent), African Americans (7 percent), and American Indian/Alaska Natives (1 percent). [13]

In 2004, 27 percent (9.5 million) of California's population was foreign-born. [14] In 2002, 27 percent of the nation's immigrants (291,191) settled in California. Nearly half (49 percent) of these immigrants were born in Latin America and the Caribbean, primarily Mexico, and 39 percent were born in Asia. [15]

In California, Hispanics are younger on average than members of other racial/ethnic groups, and this age differential is increasing. The median age of Hispanics in California in 2004 was 26, eight years younger than that of the total population (34). Among Whites, the median age was 40, and for Asians, the median age was 36. [16] Hispanic children comprised the largest proportion of school children during the 2004-2005 school year, making up 47 percent of students in California. [17]

Racial/ethnic diversity and a large immigrant population contribute to linguistic diversity in California. In 2004, 41 percent of California residents over the age of five spoke a language other than English at home, compared to 19 percent nationwide. Most often this language is Spanish, however, a variety of Asian and Pacific Island languages are also spoken. [18]

Geography

California is comprised of 61 local health jurisdictions, including 58 counties and three incorporated cities. These local health jurisdictions vary widely in geographic size, number of residents, and population density. In terms of geographic area, San Bernardino is the largest county, and San Francisco, San Mateo, and Marin Counties are the smallest. Los Angeles County is the largest in terms of population, with over 10 million residents, 28 percent of the state's total population. Alpine County has the smallest population, with fewer than 1,300 residents. [19]

Most of the state's population (98 percent) resides in urban areas [20]. Los Angeles, San Diego, Orange, Santa Clara, and San Francisco Counties all have large urban populations. Some counties, such as Fresno, Monterey, and Santa Barbara, are primarily rural but contain urban centers where most of the population resides.

Most counties in the state experienced population growth between 2000 and 2004, although the rate of growth appears to be slowing. Riverside and Placer Counties grew at the highest rate, increasing in population by approximately 4 percent each year. [21] Other counties projected to experience large increases in population include San Joaquin, Merced, and Madera. [22, 23]

Economy

In 2004, the State of California's gross product ranked eighth in the world. [24] This is in spite of the fact that California has not shared completely in the economic growth the nation has experienced recovering from the recent economic recession. California's unemployment rate in 2005 was 5.4 percent, compared to the national rate of 5.1 percent. The drop in the unemployment rate in Fiscal Year (FY) 2003-04 was the first drop in unemployment since FY1999-2000. [25] The forecast through 2008 projects that California's unemployment rate will not fall or change significantly, suggesting that the slow pace of economic growth in the state will continue. [26]

The stagnant economy in the state has resulted in budget cuts that have affected maternal and child health programs and services. The state has experienced restrictions on the creation of new contracts, purchasing of equipment, hiring of staff, and travel. This has curtailed the ability of State programs to provide technical assistance and training to local health jurisdictions, compromising the ability to improve and sustain program quality.

Restrictions on State programs and services compound existing challenges faced by California's residents who live near or below the federal poverty level (FPL). The US Census Bureau estimates that in 2004, 13.3 percent of California residents lived below the FPL. This is worse than the national rate of 13.1 percent and ranks California as the 20th worst state in terms of residents in poverty. [27] Three counties in California's Central Valley ranked among the most impoverished counties in the nation: Tulare, with 20.3 percent of residents living below the federal poverty level, Kern, with 19.3 percent, and Fresno, with 17.9 percent. [28]

The federal definition for low-income is household income of less than 200 percent of the poverty

level; however, in parts of California, the high cost of living creates stress for families whose incomes are not necessarily low by this definition. In 2004, California had the highest median monthly rental housing costs ($914 per month) in the nation, and ranked 49th for home ownership among residents. [29] The population growth occurring in California only compounds this problem, as the construction of new housing units cannot keep up with increasing demand.

While the actual cost of housing varies between different regions in California, the problem exists throughout the state. Even in lower-cost areas, affordable housing is becoming increasingly scarce. In California's rural counties, a family would need to earn at least $10.33/hour (153 percent of minimum wage) working full-time in order to afford a Fair Market Rent apartment ($537/month for a two bedroom apartment). [30]

Homelessness is also an ongoing problem for the state. For example, in Alameda County, an estimated 12,000 people are homeless on a given night, and approximately 40 percent of those are families with children. [31]

Of the 4.6 million households with one or more children under 18 in California, 19 percent are headed by a single female parent. [32] These households are more likely to struggle to support themselves with less than adequate income.

Single parenthood, low income, and high housing costs, along with welfare reform, force most women with children into the labor force. Of the almost 6.5 million women in California between the ages of 20 and 44 (as of March 2004), 70 percent participated in the labor force. [33]

The proportion of women in the labor force, coupled with the number of single-parent households in California, creates an enormous need for childcare for working parents. Unfortunately, licensed childcare is available for only 26 percent of children with parents in the labor force. The cost of childcare for a preschooler typically consumes 53 percent of a parent's income if the parent is working full time at minimum wage. [34]

Hispanics and African Americans are disproportionately low income. The 2003 median household income was $36,000 for Hispanics and $40,000 for African Americans, both well below the state's median household income of $49,320. The median household income for Whites and Asians was $71,474 and $67,064 respectively. The proportion of California residents living in poverty (<100 percent FPL) shows similar racial/ethnic disparities: 22 percent for African Americans, 21 percent for Hispanics, 11 percent for Asians, and 8 percent for Whites. Fifty percent of Hispanics and 43 percent of African Americans were classified as low income (<200 percent FPL). [35]

There are currently more than 6 million school-aged children in California and more than 9,000 schools. [36] Hispanic students comprise the largest and fastest growing racial/ethnic group in California schools. Of the student population, 49 percent receive subsidized school lunches. Over one quarter are classified as English learners; most of these English learners' first language is Spanish. [37]

Health Care Status

In California, 18 percent of the population did not have health insurance in 2002, compared to 15 percent of the US population. Among California's Hispanic population, 31 percent were uninsured. Among California children under the age of 18, 14 percent were uninsured. Among California children, 28 percent were covered by Medicaid or Healthy Families, compared to 25 percent for the US. [38] Among the poor and low-income population in California, children were more likely to be covered by public programs than adults. Continuing to raise the rates of enrollment in public insurance programs, especially among immigrants and non-English speaking populations, remains a challenge for the state.

Another challenge for the state is meeting the health care needs of the large number of

undocumented immigrants, many of whom are migrant workers. While the number of undocumented immigrants in California is difficult to measure, a recent study suggested that 2.4 million undocumented immigrants were in the State of California in 2002, over a quarter of the nation's estimated 9.3 million. It is estimated that 40 percent of the undocumented immigrants are women. [39] In one sample of undocumented immigrants in Fresno and Los Angeles Counties, half were between the ages of 18 and 34, and one quarter were children under 18. [40]

It is not surprising that, given the complicated nature of eligibility for public assistance, coupled with fear of the consequences of having to reveal one's status as undocumented, that access and participation in available services among the undocumented population is very low. Still, the most common reason given by undocumented immigrants for not seeking health care was that it was too expensive. [41] Other complications arise for undocumented immigrants who seek services in one county, then move on to another region for work. This makes it difficult to provide consistent and comprehensive services and to track services rendered to this population.

The aging of the state's population also has an impact on the health and well-being of mothers and children. In California, 16 percent of all households contain at least one caregiver for someone aged 50 or older. Three quarters of those caregivers are women, and 31 percent have their own children living at home. This can pose a financial and emotional burden on families, particularly those who are low-income and/or have working mothers. [42] Addressing this growing stress on families is likely to become an increasing challenge in the future, as the proportion of the population over age 50 grows and the cost of living forces many households to consolidate and increase in size.

The diverse nature of California's population and geography, coupled with the changing face of the population demographically, socially, and economically, proves to be a continuing challenge for the programs of California's Maternal Child and Adolescent Health / Office of Family Planning (MCAH/OFP) Branch and Children's Medical Services (CMS) Branch.

Major State Initiatives

/2008/

>Governor's Healthcare Proposal

According to the California Health Interview Survey, more than 6.5 million Californians were uninsured for all or part of the year last year. This represents 20% of children and non-elderly adults. In January 2007, Governor Schwarzenegger unveiled comprehensive plans to reform California's health care system.

The Governor's proposal is built on "shared responsibility, shared benefit" where every segment of the healthcare system (government, doctors and hospitals, health plans, employers, and individuals) has some responsibility and realizes a benefit. The three essential elements in the Governor's proposal are: 1) Prevention, health promotion, and wellness; 2) Coverage for all Californians; and 3) Affordability and cost containment.

Highlights of the proposal of specific interest to MCAH professionals and policy makers include:

- Expand Healthy Families/Medi-Cal for all children in families earning under 300% of the FPL
- $4 billion increase in Medi-Cal reimbursement rates

The Governor's emphasis on disease prevention, health promotion and healthy lifestyles promote a public health approach to improve health outcomes and help contain health care costs. Initiatives included in the Governor's proposal support the MCAH/OFP Title V priorities identified through the 2004 needs assessment process. The related Governor's initiatives are: Diabetes (prevention and control); Health Care Quality; Tobacco Control; and Obesity Prevention. //2008//

> Reorganization of CDHS

/2007/ Governor Schwarzenegger has called on the Legislature to work with him to reorganize the existing California Department of Health Services into two departments: a California Department of Public Health (CDPH) and a Department of Health Care Services (DHCS). The new CDPH would protect and promote health through a focus on population-wide interventions, while the DHCS would focus on the financing and delivery of individual health care services. The target implementation date for the reorganization is July 2007. //2007//

/2007/ In the current proposal for reorganization, the MCAH/OFP Branch is in the CDPH, and the CMS Branch is split between the two new Departments, but is primarily in DHCS. The MCAH/OFP and CMS Branches currently have joint responsibility for carrying out Title V functions; it is not clear if, or how, this partnership would be affected by the proposed reorganization. //2007//

/2008/ The CMS Branch will be located in the Systems of Care Division of DHCS. CMS Branch programs will be included in the new Division, together with Medi-Cal programs (coordinated Care managements, Disease Management and Medical Case Management). The Division Chief, as yet unnamed, will ultimately report to the Chief Deputy Director of Health Care Programs. //2008//

/2008/ The reorganization of CDHS will be implemented July 1, 2007. In preparation, CDHS has created management and transition teams to collaborate with organizational development consultants to develop the guiding principles of CDPH and DHCS, perform a SWOT analysis, create an operational plan, and promote leadership development. These efforts have been successful in assessing program placement, distributing administrative functions, developing new organization charts, and promoting budget neutrality throughout the reorganization process. The reorganization is expected to bring to CDPH a new strategic focus, positive culture change, improved business practices, and enhanced infrastructure. //2008//

/2008/ A Public Health Advisory Committee (PHAC) will also be formed to provide expert advice and make recommendations on the development of policies and programs that seek to promote the public's health. The first PHAC meeting is scheduled for September 2007. //2008//

/2008/

> Prenatal Screening Services, Umbilical Cord Blood Banking, and Pregnancy Blood Banking

Legislation passed in September 2006 will expand the California Department of Public Health's capacity to discover causes, develop prevention strategies, and increase surveillance of birth defects and genetic diseases throughout the state.

For over 20 years, the California Department of Health Services has contracted with the California Birth Defects Monitoring Program (CBDMP) to conduct research and surveillance of birth defects in California and maintain a birth defect registry that contains medical and demographic information on over 88,000 children with birth defects and monitors 334,000 births per year. This new legislation will reorganize CBDMP to become part of the MCAH/OFP Branch, thereby augmenting resources used to evaluate and analyze factors contributing to maternal, infant, and fetal morbidity and mortality. CBDMP will continue to collaborate with the Genetic Disease Branch (GDB) to maintain the Pregnancy Blood Bank, which stores prenatal screening blood samples from GDB's Prenatal Screening Program. Under this screening program, the blood samples are tested for a particular disease or disorder in a cost-effective manner in order to identify women at high risk who may require follow-up diagnostic tests.

A prenatal screening fee increase implemented in 2007 will allow both CBDMP and GDB to collect, process, store, and perform research on more blood samples than prior capacity. While the Pregnancy Blood Bank presently holds the largest number of such specimens in the country, greater volume can increase collaboration with researchers nationally and internationally, as well as provide more representative statistics on birth defects occurring in the state. MCAH/OFP Branch and CBDMP staff will be developing a database linking resource in which stored pregnancy blood samples can be linked with state health outcome data. This will provide scientists from a variety of disciplines the opportunity to test hypotheses about genetic and environmental causes of many children's and women's diseases.

The increased screening fees will also modernize and expand GDB's Prenatal Screening Program to include all prenatal screening tests that meet or exceed the current standard of care. In particular, a fourth maternal serum marker test (inhibin A) will be added to the tests available within the Program. This addition will improve the early diagnosis and management of genetic and congenital disorders and reduce the economic and emotional burden on families potentially affected by these disorders.

Depending on funds deposited in the Umbilical Cord Blood Education Account established in 2007 as part of the State Treasury, the Department may be tasked with conducting the Umbilical Cord Blood Community Awareness Campaign. The MCAH/OFP Branch would provide awareness, assistance, and information regarding public and private umbilical cord blood banking options through various media outlets and family care providers. //2008//

>Safe Motherhood

Each maternal death is tragic and represents a premature loss of life. Much of maternal morbidity and "near miss" mortality goes unnoticed by traditional public health surveillance systems and can impact maternal, fetal, and infant health.

Modeled on the California Perinatal Quality Care Collaborative (CPQCC), the MCAH/OFP Branch has developed a Maternal Quality Collaborative (MQC) to address maternal morbidity. CPQCC uses

data-oriented quality improvement activities to improve perinatal and neonatal outcomes. The MQC is a collaborative effort between the CPQCC and the UCLA Maternal Quality Improvement Group. The MQC Leadership Council includes members from CCS, MCAH/OFP, Medi-Cal Managed Care (MCMC), and Medi-Cal Policy Section. MQC measures maternal quality of care and has begun to identify hospital-level outcomes for maternal/neonatal infections and postpartum hemorrhage.

In 2006, the MCAH/OFP Branch began developing the Pregnancy-Related and Pregnancy-Associated Mortality Review Project. Maternal mortality ratios remain much higher than the Healthy People 2010 objective and racial and ethnic disparities in mortality are large. The goal of this project is to examine the medical and psychosocial events leading up to death for women who died from pregnancy-related causes or within one year of pregnancy (pregnancy-associated deaths) so that MCAH/OFP Branch and its stakeholders can develop a public health component to reduce such deaths.

The MCAH/OFP Branch is partnering with UCSF and the Public Health Institute (PHI) to identify sample cases and will abstract medical records for the antenatal, peripartum, and postnatal periods, using forms based on models provided by the CDC. A Case Review Team will review de-identified case summaries and determine whether deaths were due to pregnancy-related factors or linked to the period after pregnancy by time only. MCAH/OFP Branch, UCSF, and PHI will report findings and work with stakeholders to disseminate findings and develop next steps for action.

/2007/ The Maternal Quality Collaborative is now named the California Maternal Quality Care Collaborative (CMQCC). Dr. Elliott Main of the California Pacific Medical Center chairs the CMQCC Advisory Committee and is leading the collaboration and coordination of the CPQCC and the UCLA Maternal Quality Improvement (MQI) group. The third- and fourth-degree laceration rate of hospitals has been chosen as the first indicator for which the CMQCC will implement best practices while development and validation of other indicators proceed. //2007//

/2007/ The MCAH/OFP Branch also collaborated with the CDC Unexplained Deaths and Critical Illnesses Project, the CDC Division of Reproductive Health and the CDHS Unexplained Deaths Project to investigate the death of four women in California who died after medical abortions in 2003-2005. These deaths were attributed to infection by Clostridium sordellii, and warnings about medication and route of administration were issued by the CDC and the U.S. Food and Drug Administration during this investigation. //2007//

/2007/ The MCAH/OFP Branch is implementing the Pregnancy-Related and Pregnancy-Associated Mortality Review Project (PAMR). Chart review abstraction forms have been developed and approved by the relevant institutional review boards. Administrative data necessary for case identification has been linked. Sixty of the 194 cases identified through this linkage file have been selected for in-depth review. PHI is communicating with hospital medical records personnel to obtain permission to abstract data for these cases in the summer and fall of 2006. The MCAH/OFP Branch, UCSF and PHI have made a 5 year commitment to the continuation of this project. //2007//

/2008/ The MCAH/OFP Branch is continuing implementation of the PAMR Project. In July 2006, PHI began abstraction for the 60 cases selected for the first year's review. PHI is on schedule to complete 60 cases by June 30, 2007, as planned. Death certificates were reviewed for all 194 cases eligible for this year's review and coroner's reports were obtained for available cases in the sample. //2008//

/2008/ On February 2, 2007, the PAMR Advisory Committee held its first case review meeting. Committee members include experts in maternal and perinatal care throughout the state, including nurses and physicians affiliated with both research and community hospitals and representatives to the American College of Obstetricians and Gynecologists and the Association of Women's Health, Obstetric and Neonatal Nurses. The initial cases reviewed brought to light a number of areas for clinical and public health intervention. The Advisory Committee will meet every 2-3 months to continue reviewing case summaries and develop recommendations for CMQCC and the MCAH/OFP Branch. //2008//

/2008/ The MCAH/OFP Branch and UCSF are currently planning for the next round of case abstractions to begin July 1, 2007, including linking the administrative data needed, reviewing death certificates, and obtaining coroner's reports. Data abstraction forms will be revised prior to abstraction of data for the second year of cases to reflect possible improvements and efficiencies identified in the first year's review. //2008//

> Preconception Care

The MCAH/OFP Branch is collaborating with and supporting the efforts of the American College of Obstetricians and Gynecologists (ACOG), the California Academy of Family Physicians, the March of Dimes (MOD), the UCSF Center for Health Policy Studies, and Sutter Medical Center Sacramento to improve the practice of preconception care in California.

Through the California Preconception Care Initiative, a provider/patient resource packet has been developed to assist health care providers in the provision of preconception care. A summary of the literature provides an overview of the evidence for preconception care. Patient education handout topics include: smoking cessation; medical conditions and genetic counseling; domestic violence; folic acid use; diabetes control; infections and immunizations; and healthy lifestyle choices. In addition to the packet, clinical information has been disseminated through the Internet, regional conferences, DVD, and audio presentations.

Other states are adapting materials from California's provider/patient resource packet for their own use. The materials were distributed across the country by the National Birth Defects Prevention Network in January 2006 and are currently available for download on the March of Dimes California Chapter website. Plans are in place now to update the packet.

Over the past year, the MCAH/OFP Branch has taken a leading role in promoting preconception health and healthcare. In November 2005, the Branch convened a meeting of representatives from city, county, and state health agencies, as well as representatives from MOD and Sutter Medical Center, to discuss areas of potential collaboration.

The California Preconception Care Advisory Committee was represented, by one of its members, on the Surgeon General's Select Panel on Preconception Care. This group is providing recommendations for the nation on preconception health and healthcare. The recommendations were released in April 2006.

The California Chapter of MOD, together with the MCAH/OFP Branch, convened a Preconception Care Advisory Committee meeting in May 2006 to discuss a comprehensive, statewide plan of action to both promote and ensure access to preconception care for women of childbearing age in California. The lead program officer from the CDC and lead author of the recommendations for the nation were featured speakers. Several senior managers from MCAH/OFP participated. The committee will be meeting quarterly to prioritize the recommendations, develop a plan of action, and oversee implementation. Several members of the committee will be serving on CDC workgroups to further develop national strategies for preconception care.

The MCAH/OFP Branch is cognizant of the importance of developing and implementing Preconception Care policies that are internally consistent within CDHS programs, as well as being congruent with regional and national initiatives external to the Department. Within the CDHS, an important strategy will be to integrate Preconception Care initiatives and patient educational programs among primary care services, family planning services, and pregnancy care services, since each of these sites of clinical care may be utilized by the same individual woman, but at different times in her life. A lesson learned from the unsuccessful Preconception Care initiatives carried out in the 1990s is that isolated initiatives targeted at single provider types are not enough. Instead, the integrated, consistent, and clear guidance that a woman receives from each type of health care provider that she sees, as well as the public health educational messages that she

encounters, are critical motivators in leading to the behavioral changes that are necessary to achieve the goals of preconception care.

Local MCAH health jurisdictions have also undertaken activities related to preconception care. A prime example is the Los Angeles (LA) Collaborative to Promote Preconception/Interconception Care, which is comprised of Los Angeles County MCAH Programs (LA MCAH), LA Best Babies Network (LABBN), and the local chapter of the March of Dimes (MOD).

/2008/ Another example is the CityMatCH, AMCHP, CDC-initiated Healthy Women's Weight Collaboratives in Los Angeles and Sonoma counties; these are co-facilitated by the MCAH/OFP Branch nutritionist. //2008//

The LA County Collaborative is serving in a leadership role to implement and monitor the success of various preconception/interconception care models including 1) convening a policy roundtable to discuss financing of care for women at highest risk; 2) developing a Care Quality Framework; 3) providing case management for the highest risk women who have had an adverse birth outcome; 4) providing funding for prevention interventions; 5) surveying family needs and challenges to accessing interconception care; 6) promoting pregnancy and family friendly policies for employers; 7) implementing an evaluation framework that demonstrates the health and cost benefits of providing preconception/interconception care, as well as the elements critical for replication in other areas. This effort is largely supported by First 5 LA Healthy Births Initiative ($28 million) and LA MCAH.

/2008/ Another example of preconception care is Contra Costa County's focus on the Life Course Model developed by Dr. Michael Lu, et al. The model suggests that a complex interplay of biological, behavioral, psychological and social protective and risk factors contributes to health outcomes across the span of a person's life. The Contra Costa Maternal Child Health staff incorporates this philosophy into their MCAH, BIH, and CPSP programs and collaborates with other county and community agencies to improve the health and socioeconomic status of the community. //2008//

/2008/ A comprehensive approach to improving the health and well being of individuals throughout the lifespan has included mental health assessments and interventions for preschoolers, comprehensive school-based health centers, the development of a Youth Power Curriculum designed for high school youth to promote self actualization, improved access to health care, emergency preparedness within schools and the community, programs designed to improve family relationships, and improved access to prenatal care for pregnant women and medical care for their children. //2008//

/2008/ The Lift Every Voice project, created by the MCAH Program, was designed to address the needs of pregnant and incarcerated women in juvenile hall. Upon leaving the detention facility, women are linked to a home visitation program which supports them through pregnancy and during the baby's first year. //2008//

/2008/ The Contra Costa Preconception Care Work Group was represented at the CDC's Preconception Care Conference in Atlanta during June 2006. CDC guidelines are utilized as a framework to expand efforts related to preconception and interconception care. //2008//

The MCAH/OFP Branch has applied to the CDC for a Prevention Specialist (PS) for a period of two years to serve as the lead for a Statewide Preconception Health Task Workgroup.
/2007/ The request for the PS was not funded. //2007//

/2008/ Despite major improvements in access to prenatal care enhanced with nutrition and psychosocial education, no definite progress in the improvement of pregnancy outcomes has occurred in the United States over the past decade. In California, despite 87% of women receiving prenatal care in the first trimester, the low birthweight rate has remained constant for the past 10 years. In addition, California's infant and maternal mortality rates remain significantly higher than the Healthy People 2010 objective goals. Several evidence-based interventions recommended for

implementation during pregnancy may be more effective and beneficial if implemented before conception. Supporting healthy lifestyles and providing access to care are essential to reducing these preventable complications. //2008//

/2008/ The California Preconception Care Advisory Committee, convened in May 2006, changed its name in 2007 to the Preconception Care Council of California (PCCC). The PCCC will provide direction for: integration of preconception care in clinical and public health practice; development of financial and public policy strategies to support and sustain preconception care; and promotion of key preconception care messages to women of reproductive age in California. The PCCC formed three workgroups that are developing action plans: Research and Clinical Practice; Finance/Public Policy, and Public Health/Community. //2008//

/2008/ In an effort to move toward these goals, the California Preconception Care Advisory Council has partnered with the CDC to plan and host the second annual National Summit on Preconception Care. The 2nd Annual National Summit, scheduled to take place in Oakland in October 2007 will bring together leaders from across the country to present best practices addressing the implementation of the CDC objectives for preconception care. Funding for this Summit will come partly from the CDC, the MOD, CDPH and private donations. In preparation for this summit, the MCAH/OFP Branch has composed a fact sheet detailing the state of preconception health of non-pregnant women aged 18-44 in California. //2008//

/2008/ The MCAH/OFP Branch also participated in the Association of Maternal and Child Health Programs 2007 annual conference March 3-7 by leading the preconception care plenary session. MCAH/OFP staff conducting the session entitled “Preconception Care: Achieving Healthy Communities” covered three major objectives: 1) establish preconception care as an approach for achieving healthy communities; 2) discuss successful strategies for connecting leadership to implement national recommendations by showcasing the preconception care initiative planning and implementation strategies; and 3) explore opportunities for and challenges to adopting a new paradigm by sharing with other states the experiences of the LA Collaborative to Promote Preconception/Interconception Care. //2008//

/2008/ To quantify the impact of preconception health status on perinatal outcomes, the MCAH/OFP Branch is conducting a study examining the association of preconception hospitalizations (2000-2002) on subsequent pregnancy and birth outcomes among women 15-44 years of age in California who delivered in 2003. This study will 1) identify major causes of hospitalization for the study population; 2) identify maternal and infant health outcomes among women who were hospitalized for these major causes; and 3) compare maternal and infant health outcomes among women who were hospitalized during the three years prior to infant birth with women who were not hospitalized. //2008//

/2008/

> Teen Birth Rate Resource Project

The Branch is collaborating with the University of California San Francisco and the Office of Statewide Health Planning and Development to develop comprehensive maps of teen birth rates using geographic information system (GIS) tools. This Teen Birth Rate Resource Project (TBRR) will identify geographic locations in California with higher or lower teen birth rates so organizations can apply for resources and to target interventions to locations with greater need. The TBRR will also show whether teen birth rates have changed over time, and if this change varies by race/ethnicity and location. //2008//

/2008/

> Perinatal Care Quality Improvement

The California Children's Services (CCS), in collaboration with the Regional Perinatal Programs of California (RPPC) have developed strategies to improve the quality of perinatal care through Regional Cooperation Agreements (RCA).

The RCA requires written agreements between Regional Neonatal Intensive Care Units (NICUs) and Community and/or Intermediate NICUs specifying mutual responsibilities for activities such as education, consultation, referrals and transports, development and review of policies and procedures, and review of outcome data. The primary purpose for the RCA is to improve perinatal outcomes by coordinating systems between all levels of care in the NICUs and delivery hospitals in California.

CCS requires all hospitals participating in the program to develop and implement the RCA. In addition, all hospitals providing perinatal services in California must have written transfer/transport agreements with facilities offering a higher level of care as required by Title 22.

The RPPC have created a toolkit to assist hospitals in implementing the RCA in order to become compliant with the standard. The toolkit, which CCS approved, entitled "Agreements for Provision of Perinatal and Neonatal Care: A Step-by-Step Guide", contains detailed information on setting up a RCA, including sample documents.

CCS and RPPC published and distributed 600 toolkits to the 118 CCS-approved hospitals throughout the state. The toolkit is available on the CMS website at http://www.dhs.ca.gov/pcfh/cms/ccs/.

CCS, together with the RPPC, conducted a series of workshops throughout the state from January to April 2007 to assist hospitals in the development and implementation of the RCA.

The local CCS office and the RPPC are available to the hospitals to provide technical assistance for the development and implementation of the RCA. //2008//

/2008/

> Neonatal Quality Improvement Initiative

Children's Medical Services (CMS) Branch and California Children's Hospital Association (CCHA) are jointly sponsoring a statewide Neonatal Quality Improvement Initiative (NQI), which includes an experienced multidisciplinary project team, to improve neonatal care by working toward eliminating catheter related blood stream infections in NICUs. The NQI hospital and NICU participants are neonatologists, nurses, and administrators from the eight CCS-approved California children's hospitals and the six CCHA associate members which are the CCS-approved University of California medical centers and Sutter Memorial Medical Center (Sacramento). The Initiative is also partnering closely with the California Perinatal Quality Care Collaborative (CPQCC) for assistance with data outcome measures and to build upon their significant efforts in the area of neonatal nosocomial infections.

The approach of the NQI to improving quality at the point of care is the Institute for Healthcare Improvement (IHI) Breakthrough Series (BTS) model. In the BTS model, clinicians, administrators and other experts identify best practices and potential change strategies. A group of clinicians is then convened with the goal of testing these change strategies, learning from one another, and implementing the best demonstrated practices. Similarly, the NQI is delineating evidence-based processes of care to reduce neonatal nosocomial infections with the goal of eliminating catheter related blood stream infections; participants are receiving training and technical assistance to implement the agreed-on change package; and lessons learned are shared among participants via learning sessions with regular conference calls and focused site visits.

Outcomes, as well as observational process data, are being tracked from baseline through the course of the 9-month Initiative, ending in July 2007. A major focus of the evaluation will be a detailed analysis of the processes each site uses to implement and maintain evidence-based best practices. The most efficient and effective practices will be shared with all sites. This information can then be used to improve processes and outcomes in other CCS-approved NICUs throughout the state (118 total); benefiting all hospitalized infants, regardless of payer source. After the end of the 9-month Initiative, aggregated outcomes will be distributed to a variety of stakeholders, including the state legislature, large commercial payers, and the public. //2008//

/2008/

> Pediatric Critical Care

The CCS Program has structured a system of 19 CCS-approved pediatric intensive care units (PICUs) to assure that infants, children and adolescents have access to appropriate quality specialty consultation and intensive care services throughout the state. CCS sets standards for all CCS-approved PICUs and periodically conducts PICU site visits to help ensure standards are followed. Included in the standards is a requirement to submit annual morbidity/mortality data to CCS.

The CMS Branch, in collaboration with the University of California, Davis (UCD) School of Medicine is developing an infrastructure for Pediatric Critical Care quality care improvement. This project will assess the need for statewide benchmarking standards to direct quality improvement efforts; conduct key informant interviews with recognized leaders in pediatric critical care; analyze existing quality improvement efforts related to pediatric critical care; and develop a methodology and reporting tool to analyze pediatric intensive care quality improvement activities.

This planning effort will identify optimal approaches to the design of future database and methods for data collection from California PICUs to meet the needs of quality improvement efforts. //2008//

/2008/

> Pediatric Palliative Care

A major activity of the Children’s Medical Services Branch is to submit a palliative care waiver to the federal government. The goal of the waiver is to promote the development of comprehensive Pediatric Palliative Care demonstration programs for selected children with life limiting or life threatening conditions who are enrolled in the California Children’s Services program. These demonstration programs should improve the quality of life for these children and their family members. In addition, by providing well-coordinated, comprehensive, continuous care, cost neutrality should be achieved by reducing hospital stays and other unnecessary services.

To provide guidance on the development and implementation of the waiver, the Branch has formed a group of over 65 stakeholders that includes representatives from a variety of professional agencies, community based programs, parents, and other Divisions of DHCS.

The stakeholders have been split into 3 subcommittees to develop the specifics of the Pediatric Palliative Care program. These subcommittees include Eligibility, Service Delivery, and Outcome Data and Analysis. The Branch has also developed a Pediatric Palliative Care website and a stakeholder listserv to increase communication between the Branch and these stakeholders. The website has pertinent references on palliative care, details about the waiver, and committee minutes.

The waiver will be submitted to the federal government by January 2008 and will be implemented 6-12 months after approval. Finally, the Branch will hire an additional Public Health Medical Officer and Research Analyst to assist in the monitoring and analysis of the waiver. //2008//

> Mental health

The MCAH/OFP Branch is working to address the mental health needs of infants, children, adolescents, and mothers. The Proposition 63 Mental Health Services Act (MHSA) provides funding for the expansion of mental health services for adults and children using revenue from an additional 1 percent tax on income over $1 million. MCAH/OFP staff participate in the MHSA stakeholder group.

Many MCAH/OFP Branch programs include a mental health component, including AFLP, BIH, CDAPP, CPSP, and DV. All include assessment and referral, and some include treatment as well. Interventions may include counseling for an individual, family or group, and may address psychiatric illness, marital and family problems, alcohol and substance abuse, smoking cessation, depression, and eating disorders.

The MCAH/OFP Branch participates in statewide efforts to implement coordinated mental health services. Three such efforts currently underway are the Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers (BEST-PCP) Project; the State Early Childhood Comprehensive Systems (SECCS); and the School Readiness Initiative (SRI).

BEST-PCP brings together state agencies, including the MCAH/OFP and CMS Branches, and stakeholders to improve access to services promoting healthy mental development for children age 0-3 who are enrolled in MCMC. A model quality improvement project (including a training tool) is being implemented in two counties.

The SECCS project, funded through a HRSA grant, provides state-level leadership for programs that will help California's children to be emotionally, socially, and physically ready for kindergarten. The project coordinates various health-related programs of state and local government with organizations such as the American Academy of Pediatrics (AAP), March of Dimes, Easter Seals, and representatives of faith-based organizations.

The SRI is the signature initiative of First 5 California. Mental health counseling is one of the five "essential and coordinated elements" of SRI. It is anticipated that the SECCS initiative will strengthen the health component of the SRI, including mental health.

/2008/ In January 2007, the Maternal and Child Health (MCH) Program of the University of California, Berkeley School of Public Health, in collaboration with the MCAH/OFP Branch, the California chapter of the March of Dimes and the Department of Mental Health, submitted a grant to HRSA. Entitled *Bright Beginnings: Innovative Approaches to Improving Mental Health in California*, this grant aims to provide continuing education activities to MCH professionals in the area of maternal mental health over a three-year period. The grant is awaiting funding approval from HRSA. //2008//

/2008/ The BEST-PCP Project, which ended in early 2007, implemented developmental/mental health screening tools and referral protocols in the two primary care pilot projects. //2008//

/2008/ SECCS' staff visited local health jurisdictions to identify recommended screening tools and associated best practices, models of service integration, and barriers to braiding of funds. Reported findings will be presented to stakeholders in 2007, and plans will be developed to address many of the report findings. //2008//

/2008/

> Human Stem Cell Research and Women's Reproductive Health

California is leading the nation in its support of the advancement of stem cell research that seeks to develop treatments and cures of childhood and adult diseases. New legislation that promotes the ethical and legal conduct of human stem cell research, as well as furthers protections for women's reproductive health, has led to an influx of stem cell scientists and biotechnology companies to California. In accordance with the legislation, the MCAH/OFP Branch created the Human Stem Cell Research Unit to manage stem cell issues for the Department and to fulfill the legislative mandates related to human stem cell research (HSCR).

The HSCR Unit was formed in 2004 following the passage of Senate Bill (SB) 322. This stem cell research legislation required the Department to 1) establish a Human Stem Cell Research Advisory Committee; 2) develop statewide guidelines for research involving human embryonic stem cells and revise these guidelines as necessary; 3) collect mandated progress reports from all Institutional Review Boards (IRBs) in California regarding the status of approved projects and proposals involving stem cell research; 4) review all IRB reports; and 5) report annually to the Legislature on human embryonic stem cell research activity in California.

In February of 2006, the MCAH/OFP Branch convened the HSCR Advisory Committee. The HSCR Unit facilitated several Advisory Committee meetings to deliberate the legal, scientific, and ethical issues surrounding stem cell research. As the Advisory Committee began developing the HSCR guidelines, new stem cell research legislation (SB 1260) was introduced and passed in September 2006.

This legislation indefinitely repealed the sunset date of SB 322 and added additional stem cell research requirements including 1) greater health protections for women donating oocytes for medical research; 2) increased state reporting requirements for researchers procuring oocytes and for review committees; 3) new research oversight mandates that require Stem Cell Research Oversight Committee (SCRO) review and approval of most HSCR; and 4) biennial reviews from the Branch to the Legislature detailing stem cell research activities in California.

The HSCR Unit collaborated with the Advisory Committee to incorporate these additional provisions into the guidelines. The Unit and Advisory Committee also consulted with the California Institute for Regenerative Medicine (CIRM) to promote consistency between its stem cell regulations and those of the CDPH. Guideline consistency was an important achievement because if HSCR projects are partially funded by CIRM, then the projects must abide by both the CIRM regulations and Department guidelines.

The Advisory Committee submitted the final guidelines to the HSCR Unit in February 2007. The guidelines were approved by the Department and distributed to all IRBs, SCRO Committees, and applicable research institutions in California, along with state reporting forms and supporting materials developed by the Unit. The Unit has extended the tenure of the Advisory Committee through 2008 and will continue to consult with the members to address any necessary revisions to the guidelines and evaluate the related provisions for women's health. //2008//

> Preventing Childhood Obesity

California, like the nation, is experiencing an increase in the prevalence of obesity and related health problems. The CDHS Director has established a CDHS Nutrition and Physical Activity Action Team with representatives from both MCAH/OFP and CMS. The Action Team has proposed a $6 million Obesity Prevention Initiative consisting of community action projects, a health quality collaborative, tracking and evaluation of data, worksite interventions, and public awareness and education activities. Both MCAH/OFP and CMS are also involved in the Physical Activity and Nutrition Coordinating Committee (PANCC). /2008/ The Nutrition and Physical Activity Action Team was disbanded in FY 2006-2007. //2008//

/2007/ Childhood obesity in low-income children is assessed through the Pediatric Nutrition Surveillance System (PedNSS) data that are now on-line on the CMS Branch website. Data for 2004

show that the percentage of low-income children under 5 years receiving healthcare through CHDP who are overweight is essentially unchanged from the prior two years at 16.3 percent. For children 5-20 years, the percent overweight has continued to increase annually and is 22.4 percent for 2004 (21.7 in 2003). [43] //2007//

/2008/ The percentage of low-income children under 5 years receiving healthcare through CHDP who are overweight continues to be higher than national prevalence rates, at 17.4% in 2005. Additionally, the percent of children 5-20 years who are overweight has continued to increase annually and is higher than National Health and Nutrition Examination Survey (NHANES) III, at 22.7% in 2005. //2008//

/2008/ In California, the Child Health and Disability Prevention Program obtains nutrition status data from CHDP providers' Confidential Screening/Billing Report. California receives prevalence reports on more than 1.5 million children and adolescents, ages birth to < 20 years. Both individual county and statewide prevalence rates are available. California is one of the few states that provide data on this older age group, hence national prevalence data is not reported. //2008//

MCAH/OFP programs, including AFLP, BIH, California Diabetes and Pregnancy Program (CDAPP) and CPSP, promote healthy eating, physical activity, and breastfeeding. The MCAH in Schools Program promotes a comprehensive school health system, including physical education and healthy food choices.

The California Nutrition Network for Healthy, Active Families is a public/private partnership led by CDHS. The purpose of the Network is to promote healthy eating and a physically active lifestyle among low income Californians by using social marketing techniques to reach large numbers of people. In addition to CDHS, Network partners include the Department of Social Services (DSS), the Department of Education (CDE), the Department of Food and Agriculture, and the University of California (UC) Cooperative Extension.

/2007/ Nutrition Network funding for CHDP local programs ended in 2005. However, collaboration between MCAH agencies and local school districts has resulted in improved nutritional standards for school meals and campus snack machines, increased physical education activities and incorporation of healthy lifestyles education into school curricula. Outreach and education regarding healthy lifestyles are commonly presented to community groups, parents, caregivers and staff at child care centers and incorporated into protocols for home health visits. Walk-to-school days have been organized in several counties. //2007//

/2008/ MCAH/OFP is participating as one of eight CDPH representatives on a new Obesity Prevention Group (OPG) created by the CDHS Director's Office to coordinate obesity policy and program efforts across the Department. OPG's action items include advocating for funding and providing obesity prevention concepts to the Governor's Office. //2008//

/2008/ CDPH has developed a comprehensive strategic plan to address the obesity epidemic in California. The plan includes creating a central point of contact within state government to coordinate efforts by various sectors, such as schools and healthcare that promote active living and healthy eating environments. The plan also involves developing a statewide media campaign that frames healthy eating and healthy lifestyles as synonymous with California. Lastly, CDPH will be actively involved in supporting local assistance grants and implementing policy strategies to reduce and prevent obesity in children and adults. //2008//

/2008/ In addition, the Governor has joined the Alliance for a Healthier Generation. The Alliance seeks to prevent childhood obesity through collaborations with schools, food industry and healthcare professionals, such as CDPH and DHCS staff. //2008//

/2008/ The fourth California Childhood Obesity Conference was held in January 2007. MCAH/OFP took an active role in planning for the conference and was instrumental in the inclusion of breastfeeding, the life-cycle, adolescent interventions, as well as a preconference for county obesity

teams. The MCAH/OFP Branch convened a perinatal women's weight meeting in conjunction with the conference and took away recommendations for the Branch on improving perinatal weight. //2008//

/2008/ The MCAH/OFP Branch is co-chairing two Women's Healthy Weight Collaboratives in Los Angeles and Sonoma County. The collaboratives are technically supported by AMCHP, CityMatCH, and CDC. Many of the projects will have statewide influence; for example, Los Angeles is developing two handouts, one on breastfeeding and one on preconception weight, which will be used in state-sponsored Nutrition Network Workplace grants. //2008//

/2008/ Obesity and breastfeeding continue to be high priority areas for county Title V block grants. //2008//

/2008/

> Breastfeeding

Staff representing the MCAH/OFP Branch actively participate in the Breastfeeding Promotion Advisory Committee (BPAC) to develop strategies, recommendations, and implementation guidelines to promote, support, and protect breastfeeding in California. Throughout 2006, BPAC developed the CDPH's report of recommendations for promoting breastfeeding in California. MCAH/OFP Branch staff have provided both literary content and state, county and hospital level breastfeeding surveillance data tables and charts. The report is expected to be released in the summer of 2007. MCAH/OFP Branch is currently participating with the Women, Infant and Children Branch (WIC) to develop a CDPH Strategic Plan to address recommendations from the report.

As part of the UC Davis Breastfeeding Data Committee meeting held September 14-15, 2006, and sponsored by a CDC grant, MCAH/OFP Branch staff worked in collaboration with a variety of private and public stakeholders, including the BPAC, WIC Branch, the Genetic Disease Branch (GDB), the Office of Statewide Health Planning and Development, the California Hospital Assessment and Report Task Force (CHART), as well as private providers, such as Kaiser Permanente, Loma Linda and the UC Davis Medical Centers, and MCAH directors from Orange and San Diego counties, to review and revise the methodology for computing in-hospital breastfeeding rates. The MCAH/OFP Branch is currently revising in-hospital breastfeeding surveillance data tables (dating back to 1994) using the new methodology and will continue to annually publish county and hospital level breastfeeding surveillance tables by race/ethnicity. In addition, MCAH/OFP will provide hospital level breastfeeding rates to the CHART in support of its ongoing efforts to collect hospital performance measures for public reporting.

In order to more accurately measure in-hospital breastfeeding rates, MCAH/OFP Branch staff in consultation with various private and public stakeholders (listed above), worked to revise infant feeding categories (used to derive in-hospital breastfeeding rates) and instructions on the Newborn Screening Test form maintained by the GDB. The infant feeding categories and instructions were revised through an iterative process based upon the results of pilot testing at selected hospitals. Conference calls were held in the fall of 2006 and three rounds of pilot testing of over 200 forms were conducted. The recommended changes were reviewed and approved by the full statewide BPAC. The revised Newborn Screening Test form will be released in late 2007, with full statewide implementation expected by 2008.

Questions to assist in estimating breastfeeding duration continue to be a part of the MIHA survey and are updated in consultation with BPAC and MCAH/OFP staff.

The MCAH/OFP Branch continues to provide consultation to hospitals on developing policies which promote and support breastfeeding. The breastfeeding page of the MCAH/OFP website has expanded its hospital breastfeeding policy toolkit, Emergency Preparedness links, Infant and Young

Child Care and Feeding links, Medications and Breastfeeding links, and Family Planning and Contraception during Breastfeeding links.

The MCAH/OFP Branch provides information and support on ways to meet the requirements of the Lactation Accommodation Law and the right to breastfeed in public via website and telephone consultation. //2008//

/2008/

> Comprehensive Black Infant Health (BIH) Program Assessment

The University of California San Francisco (UCSF) Center for Social Disparities in Health has completed and submitted to the Branch a comprehensive literature review of interventions for African American infant health outcomes, including infant morbidity and mortality reduction programs. UCSF is developing recommendations for the equitable method of distributing BIH resources among local BIH programs. The final BIH intervention recommendation report and the creation of a BIH data and evaluation work group are expected by the summer of 2007. Additionally, in collaboration with the Branch and data work group, UCSF will develop a process and outcome evaluation for the BIH program. //2008//

> Black Infant Health / Fetal Infant Mortality Review (BIH/FIMR)

The BIH/FIMR Program was undertaken by the MCAH/OFP Branch in response to the persistent disparity between African American and white infant mortality rates. The goal of BIH/FIMR is to reduce African American fetal and infant deaths through review of these deaths at the community level. Eight BIH jurisdictions were selected for participation; all had an African American combined fetal and infant death rate above the average for the 17 BIH jurisdictions statewide, and all had a FIMR program.

BIH/FIMR uses the national FIMR model to collect detailed information about African American fetal and infant deaths beyond vital statistics. Data will be centrally collected and reportable at the state and county level. /2007/ The Branch is finalizing a contract with BASINET for a centralized BIH/FIMR data collection system. BIH/FIMR coordinators will be trained in its use. //2007//

/2007/ Utilizing data obtained from BIH/FIMR, the Los Angeles MCAH Program implemented the LA Mommy and Baby Survey (LAMBS) in the Antelope Valley. While the African American infant mortality rate decreased from 2002 to 2003, it still remains high when contrasted with the infant mortality rate for other ethnicities. Also of concern is the increase in infant mortality for Hispanic babies evidenced by the survey. LA MCAH has undertaken efforts to reduce infant mortality in both African American and Hispanic communities through enhanced access to quality, culturally sensitive obstetrical care for at-risk women, including home visitation and assistance with psychosocial issues. //2007//

/2008/ The Los Angeles MCAH Program piloted LA HOPE (Los Angeles Health Overview of a Pregnant Event), a population-based survey that serves as a data collection tool for maternal interviews for the LA County FIMR program. The LA HOPE survey asks women who have suffered a fetal/infant loss about a variety of topics, including preconception, interconception medical history, psychosocial factors, risk-taking behaviors, nutrition, prenatal care, environment, and grief and bereavement services. //2008//

/2008/

> Implementation of BASINET for BIH/FIMR

The MCAH/OFP Branch contracted with GO Beyond LLC to use the Baby Abstracting System and Information NETwork (BASINET) for the Black Infant Health/Fetal Infant Mortality Review (BIH/FIMR) Project. BASINET is a web-based project management system for fetal and infant mortality review that combines data abstraction, deliberations, and detailed on-demand reporting. In-person training of BASINET was provided by GO Beyond LLC in August 2006 for the eight BIH/FIMR jurisdictions that are pilot testing this data collection system with in-person follow-up trainings in January 2007. The first reports from the eight jurisdictions are expected in August 2007. Depending on the effectiveness of BASINET as a data collection system for BIH/FIMR, BASINET may be used in other counties with Branch-supported FIMR projects to provide more centralized and higher quality fetal and infant mortality data at the state and local level. //2008//

> High-risk Infants

/2007/ The CCS Program has structured a system of regional affiliation among the 114 CCS-approved neonatal intensive care units (NICUs) to assure that infants have access to appropriate quality specialty consultation and intensive care services throughout the state. CCS-approved NICUs are designated as Intermediate, Community, and Regional NICUs. NICUs that provide basic level intensive care services to infants in their communities are required to have established affiliations with NICUs that provide more extensive services, to facilitate consultation and patient transfers as needed. CCS sets standards for all CCS-approved NICUs and periodically conducts NICU site visits to help ensure standards are followed. Included in the standards is a requirement to submit annual morbidity/mortality data to CCS. The CMS Branch began requiring all CCS-approved hospitals to submit CCS NICU annual data through the California Perinatal Quality Care Collaborative (CPQCC) beginning with Calendar Year (CY) 2004 data. Reporting through the CPQCC facilitates data submission and analysis, provides feedback to the NICUs, and improves reporting accuracy. //2007//

/2007/ Each CCS-approved NICU facility is required to have an organized High-Risk Infant Follow-Up (HRIF) program or a written agreement for the provision of these services by another NICU facility to ensure follow-up. After reviewing functions and responsibilities of the NICU HRIF program and the contractual Medically Vulnerable Infant Program (MVIP), CMS is combining these two programs into one program that addresses the needs of high-risk infants. In the formative phase of combining the programs, a group of 30 stakeholders was convened and invited to provide input to CMS on ways for delivering services, defining the eligible population, defining data collection elements, and evaluating the outcomes of the program. The newly formed HRIF program will begin in July 2006, building upon the NICU HRIF programs already in place throughout the state. CMS is working with CPQCC to build upon the data that all CCS-approved NICUs currently submit. The ability to collect expanded data elements will give the HRIF programs and the NICUs the opportunity to evaluate the outcomes of their NICU high-risk infant graduates. //2007//

/2008/ The HRIF programs began submitting data using the new reporting requirements July 1, 2006. Currently the programs are submitting the data to CMS to be entered. Future planning includes electronic transmission of data for analysis and reporting through CPQCC. Some of the data reported are birthweight, gender, gestational age at birth, medical criteria, rehospitalization, visual and sight impairment, as well as several other socio-economic factors. //2008//

/2008/ The HRIF data support program evaluation and quality improvement activities. In addition, the HRIF team visit summary report provides information for case management to the county CCS programs. The data will also be a valuable adjunct to the neonatal morbidity quality improvement projects conducted by CPQCC at all CCS-approved hospitals in California. //2008//

/2008/

> Use of Data and Geographic Information System (GIS) in Policy and Planning

The MCAH/OFP Branch is participating in the Departments' GIS Working Group to establish centralized GIS tools for the Departments. This will allow for interdepartmental use of the same GIS server and will enable sharing of Departments GIS maps and data sets.
//2008//

/2008/

> Improving Quality of Vital Statistics Data

The MCAH/OFP Branch promoted changes to birth, death, and fetal death certificates to increase the data collection quality of vital statistics collected by the state. Using the birth certificate as an example, Branch efforts led to the addition of 1) obstetric estimate of gestation at time of delivery; 2) infant hearing screening; 3) maternal smoking assessment; 4) pre-pregnancy maternal weight and height measurements; and 5) APGAR scores at 1, 5, and 10 minutes.

In a complementary action, the Branch's Regional Perinatal Programs of California Coordinators (RPPC) teamed up with the Office of Vital Records (OVR) staff to provide local trainings of birth certificate clerks to improve birth certificate data collection methods, resulting in significant improvements in data completeness and quality. Some birth clerk trainings scheduled in 2006-2007 were cancelled by OVR. The need for ongoing birth clerk training remains a priority for accuracy of data. In order to address this, RPPC staff and OVR are collaborating to do an additional training session that will be videotaped and made into DVD recordings to be distributed to local hospitals.

Additionally, the Branch is working with OVR to determine whether the Branch's Sudden Infant Death Syndrome and Fetal Infant Mortality Review data collection can be incorporated into the OVR electronic death registry system.

//2008//

> Early Childhood Development

Proposition 10, the Children and Families First Act of 1998, imposes a surtax on cigarette sales, which generates revenues of about $600 million a year. The state-level commission, First 5 California, receives 20 percent of the funds, while local First 5 Commissions in each of the 58 California counties receive 80 percent. First 5 California devoted $207 million over four years (2002-2006) to its signature School Readiness Initiative (SRI). /2007/ First 5 recently reauthorized the SRI for another four years (2006-2010), with funding of $400 million. //2007//

/2007/ First 5 has several other efforts addressing early childhood health and development: 1) Health Access for All Children, a gap insurance product for children who are ineligible for Medi-Cal or Healthy Families and whose family income is below 300 percent of FPL; 2) Early Childhood Oral Health Initiative; 3) Early Childhood Obesity Prevention media campaign; and 4) Child Care Health Linkages Project. The MCAH/OFP Branch follows the activities of First 5 and helps local staff prepare SRI proposals and identify the connections between their programs and First 5 activities.
//2007//

/2007/ MCAH/OFP has received a multi-year grant beginning in 2003 from the federal Health Resources and Services Administration (HRSA) for the State Early Childhood Comprehensive Systems (SECCS) project. MCAH/OFP provides state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically ready for kindergarten. Two years of planning culminated in a statewide needs assessment and strategic plan to address critical components of early childhood health care systems. The project is now in the implementation phase. //2007//

/2008/ The current focus of the SECCS project includes identification of recommended screening

tools and associated best practices, as well as recognition of critical partners and funding opportunities to provide a seamless delivery of services. //2008//

/2008/ The National Academy for State Health Policy (NASHP) awarded MCAH/OFP a technical assistance only grant to lead a 15 month national consortium to develop policy to improve early identification of young children with developmental problems. The Assuring Better Child Health and Development (ABCD) Screening Academy Initiative's goal is to integrate valid and standardized tools of children's development into preventive health care practices. Medi-Cal, AAP, and the First 5 California Commission are the other Core Leadership Team members, and who will work with public-private partners. //2008//

/2008/

> Newborn Hearing Screening Program Expansion

New legislation expands the Newborn Hearing Screening Program (NHSP) to all general acute care hospitals with licensed perinatal services, effective January 1, 2008. The program currently is operational in 175 hospitals that deliver over 411,000 infants per year. This expansion will include 95 more hospitals and result in an additional 130,000 infants receiving hearing screening each year. It is expected that a total of 1000 infants will be identified with hearing loss every year after full implementation.

The NHSP has numerous infrastructure building blocks in place. These include standards for inpatient and outpatient screening providers, certification criteria for participation in the program, guidelines for infant audiological diagnostic evaluations, and Hearing Coordination Centers (HCCs). The HCCs are an integral component of the California program. Each one is responsible for a specified geographic service area to assure compliance with standards, tracking and monitoring of infants who need outpatient follow-up, and linkage of families of children identified with hearing loss to early intervention, medical, and support services. This infrastructure will support a seamless expansion of the program.

The biggest challenge for the NHSP during this final implementation phase will be to address the increased workload in the data management arena. The program currently collects all infant data through a paper reporting process. The NHSP is in the process of procuring a data management service that will be utilized by the hospitals, HCCs, and state office for tracking and monitoring, quality assurance, program evaluation, and statewide reporting. The service will enhance the operations of the program and improve the accuracy and reliability of the data. //2008//

> Child Health Insurance Coverage

Another major state initiative is improving the health of the Title V population through expanded health insurance coverage. Efforts to increase enrollment in the state-sponsored children's health care programs, including Medi-Cal and Healthy Families (HF), appear to be reducing the percentage of uninsured children.

/2007/ Since the inception of the CHDP Gateway in July 2003 and through February 2006, over 1.9 million children receiving CHDP assessments have been pre-enrolled for up to two months of no cost full-scope Medi-Cal benefits. Families of 70 percent of these pre-enrolled children have requested joint applications from Medi-Cal/HF. Of these, 20 percent had their eligibility extended for Medi-Cal/HF. //2007//

/2008/ From July 2003 through December 2006, over 2.5 million children receiving CHDP assessments have been pre-enrolled for up to two months of no cost full-scope Medi-Cal benefits. Of these children, 76% requested joint applications from Medi-Cal/HF and 18% had their eligibility extended. //2008//

/2007/ Effective June 2004, the CHDP Gateway was enhanced to allow deeming of Medi-Cal eligibility for infants if their mother's eligibility for Medi-Cal at the time of birth was confirmed. Eligibility is extended until the first birthday without requiring their parent(s) to complete a joint Medi-Cal/HF application. From June 2004 through February 2006, 102,449 infants were automatically enrolled in Medi-Cal as the result of a Gateway transaction. //2007//

/2008/ From June 2004 through December 2006, 157,378 infants were automatically enrolled in Medi-Cal as the result of a Gateway transaction. //2008//

> Oral Health Promotion

CDHS is responding to the high prevalence of dental disease among California's children with a variety of strategies to increase awareness of oral health. MCAH/OFP Branch staff work to ensure the inclusion of oral health promotion activities within existing programs of the Branch. Comprehensive Perinatal Services Program (CPSP) guidelines have been revised to include oral health guidelines for pregnant and postpartum women. Toothbrushes and children's fluoride toothpaste have been distributed to domestic violence shelters as well as local MCAH programs including the Adolescent Family Life Program and the Black Infant Health Program.

The MCAH/OFP Branch is contracting with University of California San Francisco (UCSF) for an oral health epidemiologist and a dental hygienist to serve as MCAH/OFP Oral Health Policy Consultants to meet the growing demand for technical assistance at both the state and local levels. The contract is awaiting state approval. The Oral Health Policy Consultants will work with Branch programs as well as being involved with the state First 5 Commission.

/2007/ The contract was approved, but has subsequently been reduced due to budget cuts. The epidemiologist position has been eliminated. //2007//

The First 5 California Commission has developed an Oral Health Initiative, which consists of 1) a $7 million Early Childhood Oral Health Education and Training Project, and 2) a $3 million Insurance-Based Oral Health Demonstration Project. Provider training began in 2004 and will continue through 2008; the demonstration project ends in 2006.

/2007/ In FY 2004-05, 1,839,706 children received dental screenings through the CHDP program, an increase of 2.9 percent from FY 2003-04 (1,788,460). CMS Branch staff continue to meet with Denti-Cal to work on solutions for improving access to dental/orthodontic care for children enrolled in the California Children's Services program. //2007//

/2008/ To assess the oral health status of elementary school children in California, the Office of Oral Health (OOH) and MCAH/OFP, along with California Department of Education (CDE), Dental Health Foundation and numerous other partners conducted dental screenings in 186 elementary schools throughout the state on over 21,000 students in kindergarten and third grade in 2005. In February 2006, the results of the assessment were published in a report entitled "*Mommy, It Hurts to Chew – The California Smile Survey – An Oral Health Assessment of California's Kindergarten and 3rd Grade Children".* This report showed that nearly three-quarters of California's low-income third graders have suffered from tooth decay. Even more distressing, 28% of children surveyed had untreated decay, and 4% of children needed urgent dental care because of pain or infection. //2008//

/2008/ The Community Water Fluoridation Program of the OOH provides scientific and technical expertise to communities interested in fluoridating their drinking water. CDPH contracts with the UCSF School of Dentistry to oversee the OOH's California Children's Dental Disease Prevention Program (CDDPP) which serves more than 342,000 California preschool and elementary school children annually. Currently, the CDDPP operates 33 school-based programs in 32 counties throughout the state, providing fluoride rinses and supplements, oral home care instruction, and

dental sealants. Plans to expand this Program into more schools in Northern California are being finalized through a grant provided by the Sierra Health Foundation. //2008//

/2008/ The MCAH/OFP Branch has contracted with UCSF School of Dentistry for a dental hygienist to serve as the MCAH/OFP Oral Health Policy Consultant. Early tooth decay prevention among children aged 6 months to 5 years is being stressed throughout the state. In June 2006, the application of fluoride varnish by doctors and nurses was added as a reimbursable Medi-Cal benefit for children younger than six years of age. Current oral health information, such as the advantages of fluoride varnish in preventing tooth decay, has been distributed among Branch program staff, as well as local jurisdictions. The First 5 California Commission is continuing the *First Smiles* program to train medical/dental providers to examine and assess their young patients' dentition and to provide fluoride varnish applications and anticipatory guidance. //2008//

/2008/ Based on a recent survey, 29 of the 61 MCAH local jurisdictions have identified oral health as one of their priorities in their 5-year implementation plans. These jurisdictions have community dental health advisory boards comprised of members from medical, dental and educational professions. The boards develop and implement local dental screening and prevention programs such as Give Kids a Smile Day in February, where volunteer dentists, hygienists and assistants provide dental screenings and treatment to low-income children. They also increase access by encouraging more pediatric and general dentists to become Denti-Cal providers. In one case, three counties have teamed up to build and staff a pediatric dental clinic that will treat low-income children that have extensive tooth decay and require general anesthesia. Other jurisdictions enlist the services of local dental and dental hygiene schools to screen and provide treatment. Fourteen jurisdictions are able to refer clients to mobile van preventive and/or treatment services. //2008//

/2008/ Five MCAH programs have a dental coordinator on staff. Other jurisdictions rely on local CDDPP and/or CHDP coordinators to integrate oral health outreach programs into MCAH target populations. Local agencies, such as Head Start, First 5, CHDP, and WIC, work to incorporate screenings, provide fluoride varnish applications, and promote preventive oral health practices to pregnant women, new parents, and children. MCAH case management programs, such as CPSP, BIH, and AFLP, enroll women and their families into Medi-Cal and Healthy Families insurance, and provide them with necessary dental referrals. //2008//

/2008/ MCAH continues to collaborate with a number of organizations concerned with promoting oral health throughout the state. These organizations include Head Start, CHDP, Oral Health Access Council and the CDPH Dental Workgroup, which is made up of members from OOH, CHDP, and Medi-Cal, as well as First 5, UCSF, Dental Health Foundation and California Dental Association. MCAH also participates with the Best Practices for Oral Health Access: California State Action Plan, which actively seeks to reduce early childhood caries in children age 0-5 years. //2008//

> Eliminating Racial and Ethnic Disparities in Health

Racial and ethnic disparities continue to exist in the areas of infant mortality, neonatal mortality, preterm delivery, low birthweight and maternal mortality in California. The MCAH/OFP Branch makes cultural sensitivity a cornerstone of every program activity, including AFLP, the Battered Women's Shelter Program (BWSP), BIH, CDAPP, and CPSP.

CDAPP incorporates cultural competence awareness in all CDAPP trainings and materials. At-risk women, including Hispanic, African American, and Asian/Pacific Islander women, are targeted. Direct services are provided by a well-trained, ethnically diverse work force of diabetes and pregnancy specialists. Food plans are developed to include foods that are compatible with the dietary customs of each client.

California's BIH programs have served as a national model by successfully identifying and enrolling the highest risk population, pregnant and parenting African American women, for focused interventions. Comprehensive services offered to this population include the development of client-

centered, culturally sensitive education, case management, and prenatal and pediatric care.

State outreach efforts have been designed to reduce the disproportionately high rates of uninsured among California's ethnically diverse populations. To improve access to Medi-Cal services, all Medi-Cal Managed Care materials are to be made available in ten threshold languages: Spanish, Chinese, Vietnamese, Cambodian, Hmong, Laotian, Korean, Russian, Farsi, and Tagalog.

/2008/

> Adolescent Family Life Program Report

In February 2007, the MCAH/OFP Branch released a report on the Adolescent Family Life Program. The report contains a history and description of the program; information about providers and funding, including fiscal challenges; a profile of female clients; and a discussion of process and outcome indicators, including early prenatal care, birthweight, repeat births and contraceptive use, educational continuation, and service referrals. It also includes some client stories.

This report is not intended to be a formal evaluation of the AFLP Program. An evaluation would require comparison of outcomes to a comparable control group that did not participate in the AFLP Program, and such a comparison was beyond the scope of this project. However, comparative data were included when they were available. For some indicators, such as birthweight, comparisons were made to teen births statewide. For other indicators, such as contraceptive use and educational continuation, comparisons were made of client behavior at entry into AFLP and at the most recent follow-up visit. Data comparing California to other states were also included. //2008//

> Adolescent Health Promotion

The state has formed the California Initiative to Improve Adolescent Health, based on the National Initiative to Improve Adolescent Health by the Year 2010. In response to the interest among county MCAH directors and local agencies, the MCAH/OFP Branch contracted with the National Adolescent Health Information Center (NAHIC) at UCSF to work with local programs to promote the plan and provide technical assistance in the development of activities.

/2007/ Due to Title V budget cuts, the adolescent health improvement contract with NAHIC has been eliminated. //2007//

NAHIC produced the Guide to Adolescent Health Data Sources to assist local MCAH directors and others interested in adolescent health to better assess the needs of youth in their community. In addition, a California Adolescent Data Update on Intentional and Unintentional Injury was developed for dissemination at the Conference on Childhood Injury Control.

/2008/ The California Adolescent Sexual Health Workgroup (ASHWG) is a standing workgroup with leadership comprised of program managers from the California Departments of Education and Public Health (MCAH/OFP Branch, STD Branch, Office of AIDS), the California Family Health Council which administers the Title X funds for California, and a local MCAH director. The workgroup is committed to working more effectively to address the sexual and reproductive health of adolescents in California. Two priority areas are currently being addressed: core competencies have been developed for the provision of adolescent sexual health education and counseling. These are being widely disseminated for feedback to assure they meet the needs of intended users. Secondly, a data integration subcommittee is working to assure easy access by local jurisdictions to sexual health and behavior data that is typically only accessible from multiple sources. //2008//

> Foster Care

California has over 84,000 foster children. To improve access to and oversight of health care for these children, the Health Care Program for Children in Foster Care (HCPCFC), a collaboration between DSS and CMS, was initiated in January 2000. This program, administered locally by the CHDP program, places public health nurses (PHNs) in administrative case management positions in welfare service agencies and probation departments to serve as a resource and to assure delivery of comprehensive preventive, diagnostic and treatment health services to children and youth in foster care.

/2007/ California now has approximately 93,000 foster children. For FY 2005-06 HCPCFC has 255 public health nurses in administrative case management and supervisory positions in welfare service agencies and probation departments. //2007//

/2008/ California now has approximately 86,000 foster children. For FY 2006-07 HCPCFC has 271 public health nurses in administrative care coordination and supervisory positions in welfare service agencies and probation departments. The number of children in foster care is decreasing primarily due to DSS efforts to keep families together and work with the whole family. //2008//

The foster care PHNs have formed a Statewide Foster Care Executive Subcommittee (of the CHDP Executive Committee) which serves the function of providing leadership to promote standardization of nursing practice in Child Welfare and Juvenile Probation in California. The Subcommittee advises the Executive Committee on program issues relating to the goal of increasing access to preventive health, dental, developmental and mental health services for children and youth in foster care. The Subcommittee provides a link to the five Regional Foster Care PHN groups through its membership, dissemination of minutes, and sharing of information relevant to health services for children and youth in foster care.

/2007/ The Subcommittee has developed four best practice guidelines for HCPCFC PHNs statewide: 1) assurance of continuity of care and case coordination among PHNs; 2) universal review and updates of the content for the Health and Education Passport (HEP) or its equivalent; 3) consultation and care coordination for out-of-county placement; and 4) guidelines for the PHN working in the juvenile probation departments. //2007//

The HCPCFC PHN directory (including state staff) and other information are online at www.dhs.ca.gov/pcfh/cms/hcpcfc/.

>Fetal Alcohol Spectrum Disorder (FASD) and the Substance Abuse Task Force

The MCAH/OFP Branch aims to improve birth outcomes for women at risk of alcohol use/abuse, including screening and referral for treatment services. Community-based prevention programs, including CPSP, BIH, AFLP, DV, and CDAPP, provide clients with information about FASD, identify those at high risk, and refer them for alcohol treatment services.

The MCAH/OFP Branch participates in a Statewide FASD Task Force. The Task Force meets quarterly and consists of representatives from state agencies and local communities. Their mission is to encourage best practices for prevention and provide intervention to those affected by FASD.

Many local health jurisdictions are also active in FASD prevention. Fresno County uses federal Healthy Start funds to identify and intervene in the lives of potentially alcohol dependent women. About half of Fresno County's CPSP providers screen for alcohol abuse using Dr. Ira Chasnoff's 4 P's Plus screening instrument. This brief, nationally-recognized tool identifies pregnant women at risk for alcohol and illicit drugs. Fresno County's Black Infant Health and Nurse Family Partnership programs also screen clients for use of alcohol.

/2007/ In addition to Fresno County, Dr. Chasnoff currently works with the California counties of Ventura, Madera, Alameda, Butte, San Luis Obispo, Humboldt, Riverside, and San Bernardino. Dr. Chasnoff came to Sacramento in February 2006 to present an update on his 4 P's Plus program to

MCAH/OFP Branch staff, local MCAH directors, and representatives of the State Office of Women's Health, Department of Rehabilitation, and Department of Social Services. //2007//

/2008/ The report, *Local MCAH Jurisdiction Survey on Prenatal Substance Use Screening Data,* was completed by Renato Littaua of the Epidemiology and Evaluation Section, Karen Ramstrom, and Maria Jocson of the Policy Section on September 22, 2006. In collaboration with the Alcohol and Other Drug (AOD) Work Group of the State Interagency Team (SIT), MCAH/OFP conducted this survey to assess the availability and format of local MCAH data on prenatal substance use. This survey provides an inventory of existing local data that can be used to complement and augment other efforts to quantify prenatal substance use statewide. //2008//

/2008/ The California Department of Alcohol and Drug Programs (ADP) in collaboration with CDPH has implemented the State Epidemiologic Outcomes Workgroup (SEOW) which is creating an ongoing method and infrastructure that will provide assessments of the prevalence and consequences of substance use throughout the State. They are particularly focused on creating a system that will provide county jurisdictions with the local data they need, and the analytic capacity to use these data effectively for prevention planning, design, and program evaluation. //2008//

/2008/ ADP has convened an expert advisory panel to serve as the SEOW and identify potential data sources. The MCAH/OFP Branch provided data to help assess the prevalence and consequences of alcohol and drug use during pregnancy, among women of reproductive age, and among children under the age of 18. The SEOW is evaluating the data sources in terms of providing meaningful and timely indicators of substance use and consequences at both the state and local levels and creating a data source summary, which served as the basis for the State EPI Profile in February 2007. //2008//

/2008/ Local health jurisdictions have partnered with public and private agencies within their county and in some cases have formed multi-county coalitions to develop and implement strategies to combat substance abuse within their communities. The partnerships provide opportunities to maximize resources, share lessons learned and expand and improve availability of services. Strategies include community education, the expansion of school curricula and identification of potential problems by school nurses, case managers and health care providers. Efforts to improve the scope and availability of school-based health clinics have also met with some success. Interagency collaboration has resulted in improved detection and resource identification for substance abusing pregnant women and their children. //2008//

> Impact of Federal Title V Reductions on California Programs

/2007/

Due to cuts in Title V funding this year, several MCAH/OFP programs have been eliminated or had their funding substantially reduced. The following programs and projects have been eliminated: Adolescent Sibling Pregnancy Prevention Program; technical assistance to local health jurisdictions for adolescent health improvement; and the training program for Adolescent Family Life Program case managers. The following have received funding reductions of more than $85,000/year each: the Adolescent Family Life Program; support services for the Childhood Injury Prevention Program; the Oral Health Program; staff support for MCAH program development; and technical assistance to local health jurisdictions from the Family Health Outcomes Project. Following is a description of the impact of these cuts.

The Adolescent Sibling Pregnancy Prevention Program (ASPPP) was eliminated in March 2006, a budget reduction of $2.3 million a year. Siblings of pregnant and/or parenting teens and their families will not receive services that assist the siblings to stay in school, encourage their use of health and safety practices, and work to prevent early onset of sexual activity and prevention of teen pregnancy. Elimination of the program may negatively impact efforts to reduce teen pregnancy.

The contract for technical assistance to local health jurisdictions on adolescent health improvement has been eliminated, at a budget reduction of $100,000 a year. As a result, technical assistance will no longer be provided to local health jurisdictions planning and implementing the recommendations provided by the Adolescent Health Improvement Plan.

Funding for training of case managers for the Adolescent Family Life Program (AFLP) has been eliminated, at a reduction of $88,000. The training provided information and skills necessary to work successfully with AFLP clients to help achieve program goals of healthy birth outcomes, improved parenting skills and completion of high school.

Funding for AFLP has been reduced by $154,000. Fewer teens and their families will receive services needed to improve birth outcomes, ensure teen program participants complete high school, and learn important parenting skills.

Funding for the support contract for the Childhood Injury Prevention Program (CIPP) has been reduced by $127,000. The reduction eliminates funding for the annual statewide Childhood Injury Prevention Conference and reduces technical assistance provided to local health jurisdictions.

Funding for the Oral Health Program has been reduced by $100,000. The goals of the Oral Health Program are to review, monitor, and improve oral health capacity for women, adolescents and children. The reduction in funding decreases the ability to provide necessary interventions, to collect data, and to collaborate with other health and oral health programs.

Due to budget constraints, one vacant senior staff position in MCAH Program Development has not been filled. Loss of this position means reduced staff capacity in the areas of policy analysis, data analysis, program development, program evaluation, and Title V reporting.

The contract for technical assistance to local health jurisdictions from the UCSF Family Health Outcomes Project (FHOP) has been reduced by $194,000. FHOP provides technical assistance to local health jurisdictions in reviewing and evaluating data for local needs assessments, a key component of the Title V Plan. The reduced funding will decrease the number of local jurisdictions receiving agency-specific technical assistance, reduce the number of training sessions and support publications, and decrease the amount of technical assistance provided to the state-level MCAH program.

The reduction in funding to the CMS Branch by $1 million has impacted the delivery of neonatal high risk infant follow-up services. As a result of these reductions, the Branch is unable to adequately fund the necessary evaluation of the program in order to determine the effectiveness of the services provided and assessment of the outcomes of the NICU graduates. //2007//

/2008/

The amount of Title V funding has not increased; however, due to the timing of funding availability from the federal grant in relationship to the state budget cycle, additional Title V funding is being allocated for the following efforts.

The Department will provide $950,000 for the California Birth Defects Monitoring Program to determine statistically valid sampling methodologies for collecting birth defects data for the Birth Defects Registry and for identifying prenatal blood samples for storage. This will enable expansion of data collection in more counties for its birth defects registry, as well as increase collection, storage, and retrieval capacity of pregnancy blood samples for research purposes.

The Department will increase funding for local MCAH services by $2 million. This funding will ensure and provide infrastructure stabilization to the 61 local health jurisdictions that have not received an augmentation in over 10 years.

The Department will allocate an additional $500,000 to Regional Perinatal Programs of California (RPPC) to provide training to hospital staff on breastfeeding to increase initiation and continuation of breastfeeding after mothers and infants are released from the hospital.

The Department will provide $225,000 for the development of strategies to improve preconception and interconception care.

The Department will provide $100,000 to support the Human Stem Cell Research Advisory Committee.

The Department is redirecting $225,000 from prior limited term local projects on childhood injury prevention to a contract with UCSF on adolescent health improvement.

The Department will provide $225,000 to expand its current efforts related to reduction of maternal morbidity and mortality. //2008//

> Impact of the Federal Deficit Reduction Act (DRA) on California Programs

/2007/ Several of the provisions of the DRA of 2005 are expected to have a negative impact on California's MCAH Programs. The new provision regarding verification of citizenship is likely to be particularly burdensome. In addition to affecting Medi-Cal, increased documentation requirements may impact other Medi-Cal-related programs, including Family PACT (family planning services for teens and low-income women), and the Comprehensive Perinatal Services Program (CPSP). //2007//

/2007/ Research consistently shows that increased documentation requirements are barriers to Medi-Cal enrollment. Low-income applicants may not have the needed documentation in their possession and may find their health coverage delayed or denied altogether while they attempt to obtain it. The cost of obtaining the required documentation may be prohibitive. For teens who are eligible for confidential services (for family planning, for example), parental intervention may be necessary for obtaining verification of citizenship, thereby effectively eliminating the teens' access to confidential services. Citizenship verification requirements are also likely to intensify a commonly cited barrier to healthcare among immigrants - the fear of authorities and fear associated with immigrant status. Finally, some providers may stop providing services because they find the new verification requirement to be too onerous. //2007//

/2007/ The effect of the new verification of citizenship requirement may ultimately be reflected in an increasing teen birth rate, an increasing number of poor birth outcomes, and a decline in access to healthcare for pregnant women and children. //2007//

/2008/ California is in the process of implementing the DRA. The concerns described above regarding the impact of DRA are still applicable. //2008//

B. AGENCY CAPACITY

The programs of the MCAH/OFP and CMS Branches include the following:

Adolescent Family Life Program (AFLP)
AFLP Management Information System
Adolescent Health Program
Advanced Practice Nursing Program (APN)
Battered Women's Shelter Program (BWSP)
Black Infant Health (BIH)
BIH Management Information System

Breastfeeding Promotion
California Birth Defect Monitoring Program (CBDMP)
California Children's Services (CCS)
California Diabetes and Pregnancy Program (CDAPP)
California Perinatal Quality Care Collaborative (CPQCC)
California Perinatal Transport System (CPeTS)
Child Health and Disability Prevention Program (CHDP)
Childhood Injury Prevention Program (CIPP)
Comprehensive Perinatal Services Program (CPSP)
Comprehensive Perinatal Services Provider Training
Emergency Triage Transport System (ETTS)
Family Health Outcomes Project (FHOP) and Local MCAH Data
Family Planning Access Care and Treatment (Family PACT)
Fetal Infant Mortality Review Program (FIMR) and BIH FIMR
Genetically Handicapped Persons Program (GHPP)
Health Care Program for Children in Foster Care (HCPCFC)
High Risk Infant Follow-up
Maternal Child and Adolescent Health Program (MCAH)
MCAH in Schools (formerly named School Health Connections)
Medical Therapy Program (MTP)
Newborn Hearing Screening Program (NHSP)
Oral Health
Perinatal Profiles and Improved Perinatal Outcomes Data Reports Website
Regional Perinatal Programs of California (RPPC)
Sudden Infant Death Syndrome (SIDS) Program
Teen Pregnancy Prevention Programs
Youth Pilot Program (YPP) and Integrated Health and Human Services Pilot

/2008/

In the last two years, the above list of programs has changed as follows:

- The Adolescent Sibling Pregnancy Prevention Program (ASPPP) was eliminated in 2006 due to Title V funding cuts.

- The Adolescent Health Program was eliminated in 2006 due to Title V funding cuts, but is being reinitiated in 2008 with redirected funding.

- Effective January 2007, California's Birth Defect Monitoring Program was moved from the CDHS Prevention Services Branch to the MCAH/OFP Branch.

- The Emergency Triage Transport System is a new project funded through an Inter Agency Agreement with the CA Emergency Preparedness Office; HRSA grant.

- The Youth Pilot Program (YPP) and Integrated Health and Human Services Pilot has been removed from the list of MCH programs because the MCAH/OFP Branch no longer has responsibility for it. The CDHS Administration Division now has oversight responsibility for this effort.

//2008//

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

> Support to local infrastructure

Several system-wide programs, including MCAH, CCS, and CHDP, are administered by local health

departments under the direction and guidance of the MCAH/OFP and CMS Branches. In addition to setting statewide policy, the State funds local health departments for these activities.

The Youth Pilot Program (YPP) facilitates integration of CDHS services for youth in six counties. The YPP pilots allow counties to make decisions locally regarding the best use of state and local human services funds without a reduction of state and federal funds.

> Quality of maternity services

The California Perinatal Quality Care Collaborative (CPQCC) is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals (including MCAH/OFP and CMS), and business groups. It is working to develop an effective perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels. CPQCC membership has grown to over 100 hospitals. Participating hospitals receive an annual online report with comparative analysis on perinatal and neonatal data.

/2008/ CPQCC membership has grown to 123 NICUs, three of which are in the final stages of the application process. These 123 hospitals represent over 90 percent of all neonates cared for in California neonatal intensive care units. //2008//

/2007/ CPQCC has developed a quality assurance tool for use by hospitals in evaluating the quality of neonatal services and a CPQCC team visits member hospitals to assist with the process. //2007//

The Perinatal Quality Improvement Panel (PQIP), a subcommittee of CPQCC, recommends quality improvement objectives, provides models for performance improvement, and assists providers in a multi-step transformation of data into improved patient care through the use of toolkits, workshops, and follow-up. MCAH/OFP and CMS staff are members of the CPQCC Executive Committee and PQIP.

The MCAH/OFP Branch recently developed the Maternal Quality Collaborative (MQC), a joint effort with the CPQCC and UCLA's Maternal Quality Indicators group. The MQC Leadership Council includes members from CCS, MCAH/OFP, MCMC, and Medi-Cal Policy Section. The MQC will direct statewide maternal quality improvement activities utilizing the methodology developed by the CPQCC.

CDAPP works to promote optimal management of diabetes in at-risk women, before, during and after pregnancy. CDAPP has care guidelines which address everything from lab values to billing and data issues. /2008/ CDAPP staff have begun the process for updating the CDAPP “Guidelines for Care” Manual. //2008//

>Infants' access to care

Medi-Cal, Healthy Families (HF) and Access for Infants and Mothers (AIM) provide health insurance coverage for infants. Medi-Cal reaches infants living in households with incomes below 200 percent of FPL. HF provides insurance coverage for infants in households with incomes up to 250 percent of the FPL; monthly premiums and co-payments for certain types of visits and prescriptions are required. AIM provides state-subsidized third party insurance for infants in households with incomes between 200 and 300 percent of FPL.

/2007/ Preventive screening and basic health services are provided to infants under one year of age by the CHDP program. In FY 2003-04, 555,953 infants under one year of age received health services through CHDP, a 5 percent increase over the previous year. Of these infants, 75 percent had Medi-Cal coverage and 25 percent were state-funded. The largest ethnic group is Hispanic (68 percent). //2007//

> Infant Health Promotion

CDHS promotes exclusive breastfeeding initiation at birth and breastfeeding during infancy. Breastfeeding is promoted across all MCAH/OFP programs serving pregnant women and infants. Informational materials regarding breastfeeding, nutrition and immunizations for women, adolescents, children, and infants, are regularly disseminated to AFLP, BIH, CPSP, and RPPC providers. The CDAPP Guidelines for Care include a chapter on breastfeeding. The MCAH/OFP website includes a page devoted to breastfeeding. The page includes data on postpartum hospital breastfeeding discharge rates, local breastfeeding coalitions, links to other breastfeeding resources, and model breastfeeding policies.

/2007/ In 2006 MCAH/OFP and CMS completed a chapter on infant feeding for the California Daily Food Guide. The chapter, which promotes breastfeeding as the normal infant feeding method, is available on the MCAH website and serves as the state-wide recommendation for infant feeding. //2007//

/2007/ MCAH/OFP offers technical assistance to hospitals to improve their breastfeeding policies. A toolkit, to assist hospitals in adopting model hospital policies, was completed in 2006 and is available on the breastfeeding web page. MCAH staff have been working with Kaiser staff to facilitate Kaiser's effort to have all their labor and delivery facilities in Northern California adopt the model hospital breastfeeding policies. //2007//

/2008/ MCAH/OFP promotes exclusive breastfeeding for the first 6 months of life and the continuation of breastfeeding for the first year and beyond. The MCAH/OFP website's breastfeeding page now includes updated data on hospital breastfeeding rates, a model hospital policy toolkit and links to other resources for health care providers and hospitals that offer support for mothers who choose to breastfeed and return to work, need information on contraception, take medications or face emergencies. //2008//

Birth defects remain the number one cause of infant deaths. While the causes of many congenital defects have yet to be identified, effective measures for the prevention of a significant portion of neural tube defects are known. MCAH/OFP Branch activities focus on folic acid promotion during the preconception and prenatal periods to reduce the risk of neural tube defect-affected pregnancies. The MCAH/OFP Branch is an active participant on the National Council on Folic Acid.

/2008/ In 2006, the MCAH/OFP Branch contributed a chapter entitled "Folic Acid Use Among California Women of Reproductive Age, 2004-2005" to a report on the California Women's Health Survey by the Office of Women's Health. //2008//

The Genetic Disease Branch (GDB) of CDHS provides newborn screening for primary hypothyroidism, phenylketonuria (PKU), galactosemia, sickle cell disease and other hemoglobinopathies to 99 percent of the newborn population. The Newborn Screening (NBS) Program is expanding to include over 40 additional metabolic conditions detectable via Tandem Mass Spectrometry, and classical congenital adrenal hyperplasia. CMS is working with the GDB to inform CCS-approved Special Care Centers (SCCs) and CCS County and Regional Offices of the expansion and to enlist their help in expediting referrals for infants with positive screening test results.

/2007/ In July 2005, the Newborn Screening (NBS) Program expanded to include classical congenital adrenal hyperplasia (CAH) and over 40 additional metabolic conditions detectable via Tandem Mass Spectrometry (MS/MS). //2007//

/2008/ From July 2005 through August 2006 (639,158 screens), there were 1,150 positive screens, and 198 cases of inborn errors (including PKU) diagnosed by MS/MS testing. From July 2005 through December 2006, 54 cases of CAH were diagnosed. The CAH cutoff for infants <1000g was

increased in March 2006 resulting in the false positive rate dropping from 20 percent to 4 percent. //2008//

/2008/ The NBS Program is expanding in August 2007 to include Cystic Fibrosis and Biotinidase Deficiency. //2008//

Several programs of the MCAH/OFP Branch address additional causes of infant mortality and morbidity. The SIDS Program has facilitated the SIDS Risk Reduction campaign, also known as Back to Sleep (BTS) in California.

/2007/ Between 1999 and 2004 the rate of infant deaths due to SIDS in California declined 31.4 percent, from 45.7 per 100,000 live births to 31.4 per 100,000 live births. In 2004 African American infants had the highest rate of SIDS at 83.7 per 100,000 live births, followed by 40.2 for White/Other infants and 23.6 for Hispanic infants. //2007//

The Black Infant Health (BIH) Program has the goal of reducing African American infant mortality in California. BIH funds programs in 17 local health jurisdictions, which, combined, account for 94 percent of the state's African American births.

California's Fetal Infant Mortality Review (FIMR) Program, which took a significant budget cut in FY 2002-03, was expanded this year, with a $250,000 reallocation of Title V funds. This new funding has established the Black Infant Health FIMR (BIH/FIMR) Program. The goal of the BIH/FIMR program is to reduce African American fetal and infant deaths through review of these deaths at the community level. Eight of the seventeen FIMR jurisdictions with the greatest proportion of African American births have been selected for participation.

The MCAH/OFP Branch prepared a grant application to CDC for a Fetal Alcohol Syndrome Program, but it was not funded. MCAH/OFP continues to network with counties that are addressing Fetal Alcohol Spectrum Disorder (FASD).

/2008/ As of March 2007, there are 175 hospitals certified and participating in the NHSP, down from 177 in the previous year. This number has decreased due to the closure of delivery units in some CCS approved hospitals. Of the babies born in CY 2005, over 411,000 received newborn hearing screening and 713 were identified with hearing loss. This is an incidence rate of 1.7 per 1000. Of those with hearing loss, 450 were identified before 3 months of age (63%), and 598 have been enrolled in Early Start, California’s early intervention program (84%). Of those in Early Start, 403 enrolled before 6 months of age (67%). //2008//

Preventive and Primary Care for Children

> Access to care

Medi-Cal and HF provide access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children. Medi-Cal covers children ages 1 through 5 up to 133 percent of FPL, children and adolescents ages 6 up to 19 at up to 100 percent of FPL, and young adults ages 19 to 21 at up to 86-92 percent of FPL. HF covers children from 0 through 18 years of age who are uninsured and living in households with incomes up to 250 percent of FPL. Monthly premiums and co-payments for certain types of visits and prescriptions are required.

/2007/ As of December 2005, there were 742,325 children enrolled in HF. This is a 6.5 percent increase from December 2004. //2007//

/2008/ Increased efforts have been made by local health jurisdictions to ensure medical care for the MCAH population. Efforts include training certified application assistants to identify the most appropriate health insurance program for women and their children; training pediatricians to perform

routine dental exams on their population; and encouraging dentists to accept Denti-Cal patients. //2008//

The CMS Branch administers the screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, which is called the Child Health and Disability Prevention Program (CHDP) in California. CHDP provides preventive services, including health assessments, immunizations, screening tests, dental screening, health education, and referral for further diagnosis and treatment for Medi-Cal-funded children up to 21 years of age. Uninsured children and youth up to 19 years of age in families with incomes at or below 200 percent of the FPL are eligible to pre-enroll in Medi-Cal through the Gateway process.

/2008/ In FY 2006-07, 2,039,935 children received screening and health assessments through the CHDP program, similar to the previous year. (The number receiving services declined by 3 percent in FY 2005-06, after having been quite stable at about 2.1 million for the previous five years.) The funding for the CHDP program remains the same as the previous year: 98 percent funded by Medi-Cal and 2 percent by state only funding. //2008//

The CHDP Gateway, implemented in July 2003, has pre-enrolled 1.2 million children through February 2005, and 80 percent of them have requested a joint Medi-Cal/HF application. CDHS has modified the pre-enrollment process that allows the Gateway transaction to identify and "deem" certain infants less than one year of age as eligible for ongoing, full-scope, no cost Medi-Cal at the time of a CHDP health assessment. The families of these infants do not have to complete a Medi-Cal application.

/2008/ The CHDP Gateway program pre-enrolled 2.5 million children from July 2003 to December 2006, and 76 percent have requested a joint Medi-Cal/HF application. From February 2005 to December 2006, 157,378 infants have been “deemed” eligible for full-scope, no cost Medi-Cal as a result of the modified CHDP Gateway pre-enrollment process. //2008//

> Childhood/adolescent health promotion

Injuries are the leading cause of mortality among children and youth. To reduce injury-related mortality and morbidity among children and adolescents, MCAH/OFP contracts with the Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University. CIPPP provides technical assistance and training for local MCAH programs through conferences, a list serve, and weekly literature reviews of the latest injury prevention research. The MCAH/OFP Branch funds five local MCAH jurisdictions to increase injury prevention capacity within their community.

/2007/ Due to Title V budget cuts, funding for the MCAH/OFP contract with CIPPP has been reduced. The reduction eliminates funding for the annual statewide conference and reduces technical assistance provided to local health jurisdictions. //2007//

/2008/ The funding specifically for childhood injury prevention in five local jurisdictions will be discontinued after June 2007. Counties are expected to continue to address childhood injury prevention issues with their general funding allotment. Counties have also received grants from the Office of Traffic Safety, which have enabled them to expand childhood injury prevention programs. //2008//

As a part of the California Initiative to Improve Adolescent Health by the Year 2010, the National Adolescent Health Information Center (NAHIC) and the California Adolescent Health Collaborative (AHC) provide support to local jurisdictions interested in adolescent health. Last year the Guide to Adolescent Health Data Sources was produced to assist locals in assessing the needs of the youth in their community. NAHIC and AHC provide technical assistance to assist local programs in developing a grant application template that they can use for future applications to foundations and federal agencies. The California AHC also puts out an annual report card on key adolescent health indicators.

The MCAH/OFP Branch applied for a System Capacity for Adolescent Health Technical Assistance Grant from the Association of Maternal and Child Health Programs (AMCHP), but did not receive one.

The MCAH/OFP Branch held an Adolescent Health System Capacity Assessment stakeholder meeting in April 2005, in addition to local feedback meetings with MCAH Directors and other groups. Results of these meetings reveal that there is a great need to increase efforts in general adolescent health at the MCAH/OFP Branch and increase partnerships, especially in the areas of mental health, education, substance abuse, and juvenile justice. Local jurisdictions want to see more state staff attending local events and visiting programs so that stronger partnerships between state and local programs can be fostered. Local jurisdictions also expressed a strong need for more financial and human resources for adolescent health so that they could implement California's adolescent health strategic plan at the local level.

/2007/ Due to Title V budget cuts, the contract with AHC for adolescent health improvement has been eliminated. Technical assistance will no longer be provided to local health jurisdictions planning and implementing the recommendations provided by the Adolescent Health Improvement Plan. //2007// /2008/ This adolescent health promotion project will be re-initiated in 2008 with redirected funding. //2008//

The MCAH/OFP Branch participates in the multi-agency California Coalition for Youth Development. The coalition works to improve youth development throughout California through the annual Youth Development Summit and other projects. Participants include the Attorney General's Office, CDE, 4-H Center for Youth Development, Friday Night Live, Department of Alcohol and Drug Programs (ADP), and the Department of Mental Health (DMH).

/2007/ MCAH/OFP has received a multi-year grant beginning in 2003 from HRSA for the State Early Childhood Comprehensive Systems (SECCS) project. MCAH/OFP provides state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically ready for kindergarten. Two years of planning culminated in a statewide needs assessment and strategic plan to address critical components of early childhood health care systems. The project is now in the implementation phase. //2007//

/2008/ SECCS staff visited 8 local health jurisdictions to identify screening tools and best practices, models of service integration, and barriers to braiding of funds. Findings will be presented to stakeholders in 2007, and plans will be developed to address the findings. //2008//

The MCAH/OFP Branch participates in UCSF's Childcare Health Program Advisory Committee. This organization is dedicated to enhancing the quality of childcare for California's children by initiating and strengthening linkages between health, safety, and child care communities and the families they serve. This program previously received the Healthy Child Care America (HCCA) Grant, which has now been folded into the SECCS grant. UCSF's HCCA director serves as the co-director for the SECCS grant. /2008/ The MCAH/OFP Branch did not participate on this Committee in 2007 due to staff changes. //2008//

The CMS Branch continues to participate in the Childhood Asthma Initiative (CAI) through the CAI CHDP project, consisting of asthma education, trainings, resource development, and implementation of Asthma Assessment Guidelines for CHDP providers. /2007/ The Childhood Asthma Initiative grant ended July 2005. //2007//

> Services for Children with Special Health Care Needs (CSHCN)

The CMS Branch administers the CCS program that provides case management and payment of services for CSHCN. The program authorizes medical and dental services related to the CCS eligible condition. Additionally, it establishes standards for providers, hospitals, and Special Care

Centers (SCCs) for the delivery of care in tertiary medical settings and in local communities, and provides physical and occupational therapy and medical case conference services at selected public school sites for children with specific medically eligible conditions.

/2007/ The CCS Medical Therapy Program (MTP) provides physical and occupational therapy services to children with CCS MTP eligible conditions. There is no financial eligibility requirement. The number of clients enrolled in the MTP has remained fairly stable for the past four years and is currently 26,698. //2007//

/2008/ The estimated caseload for CCS in Federal Fiscal Year (FFY) 2005-2006 was 182,800. This is a four percent increase from the prior year of 175,920. Approximately 80 percent of these children were enrolled in Medi-Cal, 10 percent were enrolled in HF and 10 percent were enrolled in state-only CCS. CHDP providers continue to facilitate referrals to CCS of children with CCS eligible or potentially CCS eligible conditions. //2008//

The CCS program is responsible for case managing the care of the CCS eligible condition for Medi-Cal beneficiaries and authorizes Medi-Cal reimbursement for services related to the CCS condition, including EPSDT supplemental services. CCS case manages and authorizes payment of services related to the CCS eligible condition for children enrolled in HF. Through a system of CCS-approved SCCs, CCS provides access to quality specialty and subspecialty providers for CSHCN. The SCCs are located in the outpatient departments of tertiary care hospitals and use multidisciplinary teams to address health needs and provide coordinated care for CCS beneficiaries.

Thirty-one "independent" counties fully administer their own CCS programs, and 27 "dependent" counties share the administrative and case management activities with CMS Branch Regional Offices. The Case Management Improvement Project has encouraged dependent counties to assume case management functions historically done by state Regional Office staff.

The CCS Program has structured a system of regional affiliation among the 121 CCS-approved neonatal intensive care units (NICUs) to assure that infants have access to appropriate specialty consultation and intensive care services throughout the state. CCS-approved NICUs are designated as Intermediate, Community, and Regional NICUs. NICUs that provide basic level intensive care services to infants in their communities are required to have established affiliations with NICUs that provide more extensive services, to facilitate consultation and patient transfers as needed. The CCS approval process denotes the level of patient care provided in each NICU and verifies that the cooperative agreements are in place. In June 2001 the CPQCC initiated annual NICU data reporting to CCS. Annual NICU reporting is required for continuing CCS approval and reporting through the CPQCC facilitates data submission and analysis and improves reporting accuracy. The CMS Branch is requiring all CCS-approved hospitals to submit CCS NICU annual data through CPQCC beginning with CY 2004 data.

/2008/ The number of CCS-approved NICUs is currently 118. To date all but one CCS-approved NICU are submitting data to CPQCC for 2006. //2008//

The CMS Branch has two programs that address the needs of high-risk infants. The first allows infants that are discharged from CCS-approved NICUs to be followed in NICU High Risk Infant Follow-up clinics. Three multidisciplinary outpatient visits are authorized by CCS during the first three years of life to identify problems, institute referrals, and monitor outcomes. Visits include a comprehensive history and physical examination, developmental testing, and ophthalmologic, audiologic, and family psychosocial evaluations.

The second program, the Medically Vulnerable Infant Program (MVIP), has used a network of community-based contractors to provide home-based services to high-risk infants from NICUs and their families. Services have been provided to infants up to three years of age. Twelve contractors, including hospitals, community-based organizations and universities, have contracts until December 2005. As of March 2005, 4,282 infants have been enrolled in the program and 51,280 home visits have been made since program inception in July 2000.

/2007/ After reviewing functions and responsibilities of the NICU High Risk Infant Follow-up (HRIF) program and the MVIP, CMS is combining these two programs into one program that addresses the needs of high-risk infants. The newly formed HRIF program will begin in July 2006, building upon the NICU HRIF programs already in place throughout the state. CMS is working with CPQCC to build upon the data that all CCS approved NICUs currently submit. The ability to collect expanded data elements will give the HRIF programs the opportunity to evaluate the outcomes of their NICU high-risk infant graduates. //2007//

/2008/ The 43 HRIF programs submitted 3169 registration forms between July 1, 2006 and May 15, 2007. //2008//

The Genetically Handicapped Persons Program (GHPP) provides case management and funding for medically necessary services for people with certain genetic conditions. Most GHPP clients served in this program are adults, but 10 percent are children under 21 years. The GHPP serves eligible children with higher family incomes that make them ineligible for the CCS program. Hemophilia is the most common GHPP diagnosis followed by cystic fibrosis, sickle cell disease, Huntington's Disease, and Friedreich's Ataxia. /2007/ Client enrollment in GHPP is stable at about 1,550 clients (2005-2006). //2007//

> Rehabilitation services to Supplemental Security Income (SSI) beneficiaries under the age of 16

SSI beneficiaries with a CCS medically-eligible diagnosis are served by the CCS program. During FY 2003-04, CCS received 2,057 referrals of SSI beneficiaries, and 52 percent of these were medically eligible for the CCS program. If physical and/or occupational therapy are needed, they can be provided in the CCS MTP. Children receiving SSI who have mental or developmental conditions are served by DMH, Department of Developmental Services (DDS), and CDE.

/2007/ During FY 2004-05, CCS received 550 referrals of SSI beneficiaries, and 46 percent of these were medically eligible for the CCS program. //2007//

> Family-centered, community-based coordinated care for CSHCN

SCCs and hospitals that treat CSHCN and wish to become CCS-approved must meet specific criteria for approval. One of the criteria used in evaluation involves provision of family-centered care (FCC). During the facility review, FCC is assessed and, as part of the review, the CMS Branch sends a follow-up report to the facility with FCC recommendations.

The CCS program facilitates FCC services for families of CSHCN. CCS staffing standards allow a parent liaison position in each county CCS program to enable FCC. County programs assist families in accessing authorized services. Many families live long distances from the site of appropriate pediatric specialty and subspecialty care. The program provides reimbursement for travel expenses (gas, bus tickets, taxis), meals for extended stays, and motel rooms for families when there are extended hospital stays.

The Children's Regional Integrated Service Systems (CRISS) (a collaboration of family support organizations, pediatric providers, statewide organizations, 14 county CCS programs in Northern California, and Family Voices of California) has a FCC Work Group that meets bimonthly. This group plans, develops and sponsors an annual fall conference (in addition to assisting with other conferences, workshops, resource fairs, and addressing issues regarding FCC); the conference for 2004 was about sexuality and youth with disabilities. /2007/ The conference for 2005 was entitled, "What Happens at 18? Conservatorship and Other Legal Rights for the CCS Client." //2007//

/2008/ The 2006 Annual CRISS Conference, “Negotiating Multiple Transition Hurdles, One at a Time”, was held in November. A CRISS mid-year workshop, “Maintaining Compassion and Avoiding

Burnout", was held in June 2007. //2008//

The CMS Branch has been directing a Champions for Progress Center Incentive Award that has involved convening a group of key stakeholders, with past investments in and knowledge of the system of care for CSHCN and their families, to meet bimonthly for twelve months to develop strategies and an action plan to address the CSHCN Title V performance measures and prioritize issues resulting from the Title V Needs Assessment process. The project is building on past efforts to develop a long-term, strategic plan for serving CSHCN; it is identifying resources within California to carry out the activities defined in the strategic plan. /2007/ There have been 25-30 stakeholders consistently participating in these monthly meetings. //2007//

/2008/ The action plan was completed and disseminated. Implementation activities are being discussed by the Key Stakeholder Group for the MCHB grant described below. The Stakeholder Group will continue to meet quarterly, through June 2008. //2008//

A federal Maternal and Child Health Bureau (MCHB) grant has been awarded to the University of Southern California's University Center for Excellence in Developmental Disabilities at Children's Hospital Los Angeles (CHLA), collaborating with CRISS and Family Voices of California, for a three-year project to implement integrated community systems of care for CSHCN.

CCS is collaborating with CHLA and the California Epilepsy Foundation on a grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy. The overall goal of the project is to improve access to health and other services and to facilitate the development of state-wide community-based interagency models of comprehensive, family-centered, culturally-effective care and state-wide standards of care.

LA County CCS produced a "Handbook for Los Angeles County CCS Families" in English and Spanish after working for two years with low-income, English and Spanish-speaking parents, Family Resource Centers, TASK (Team of Advocates for Kids), providers, Regional Centers, and LA CMS staff.

> Transitioning services for CSHCN

The CMS Branch recognizes the importance of transitioning care for CSHCN from pediatric to adult services. During site reviews of new SCCs and county CCS programs, transition issues are emphasized as important for the future delivery of medical care and services to the CSHCN.

CCS staff in Southern California regularly attend and participate in the Special Education Local Planning Areas (SELPA) Interagency Coordinating Transition Council. Transition committees in local county CCS programs receive input from parents and young adult clients to assess and develop ways to infuse the concept of transition into CCS services and functions. A matrix of transition activities of each of the fourteen represented counties is maintained

The CMS Branch formed a transition workgroup that has begun meeting and will ultimately develop transition policy and guidelines for the CCS program. There are healthcare professionals, experts in transitioning care, and family representatives.

/2007/ The transition workgroup has completed a survey that is being sent to county and Regional Office CCS programs to better understand what local and state CCS programs are doing to foster transition services and what the needs are for transition resources, technical assistance and training. This workgroup will also be reviewing the transition strategies from the Champions stakeholder group to help determine an implementation plan for these strategies. //2007//

/2008/ Surveys were distributed to all county CCS programs. Counties were asked a series of questions for each of four MCHB core performance measures and asked to score their performance

on a prescribed scale. CRISS staff have collected and summarized the survey data from 51 of the 58 counties. //2008//

/2008/ The counties were asked the degree to which the local CCS program provides the services necessary to effect appropriate transitions to adult health care, work and independence for youth with SHCN. Rural dependent counties scored higher than larger urban and/or independent counties in the area of transition. The rural counties did not hold transition clinics, but they reported meeting with each transitioning youth (of which there may have been a small number). There was almost 100 percent compliance with the counties reporting "durable medical equipment needs, self-help needs and other MTP skills being assessed in a timely manner so that the youth at 21 exits the program with appropriate supports." In contrast, many counties outside the CRISS counties and LA (the latter where transition has been a focus) reported "no development or adaptation of transition materials" for use with their exiting young adults. Identification of adult providers was the second lowest mark for this performance measure. The average score for this performance measure was 2.53, right between "partially" and "mostly met". //2008//

/2008/ The final report was submitted to CMS in August 2006 and has been distributed to all county CCS programs. The survey results also are being discussed in the context of the quarterly meetings of the State Key Stakeholder Group overseeing implementation of the State CCS Plan. //2008//

/2007/ CHLA, UCLA Child and Family Health Program, LA Partnership for Special Needs Children, CRISS, CCS, and CMS Branch collaborated on a conference entitled "Family-Centered Strategies for Effective Transition for Youth with Special Health Care Needs: A Training for Providers and Families" in April 2006 in Los Angeles. Experts in the field provided information to agency staff, providers, youth and their families about the system of care for transitioning youth, transition resources, and strategies for assisting youth and their families. //2007//

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National and State Performance and Outcome Measures and Health System Capacity Indicators

NOTE: The reporting year for the Federal Fiscal Year 2007-2008 Title V Block Grant Application/Annual Report is 2006. The 2006 data shown in italics below are provisional data based on 2005 final data. Proposed annual objectives in this report are for the 2007-2011 time period.

California Title V *National* Performance Measures

	National Performance Measure	*Year*	*Measure*	*Year*	*Objective*
1.	Percent of infants who are screened for conditions mandated by their State-sponsored newborn screening programs (e.g., phenylketonuria and hemoglobinopathies) and receive appropriate follow-up and referral as defined by their State.	2001 2002 2003 2004 2005 *2006*	98.4 98.7 99.5 100.0 99.2 *99.2*	2001 2002 2003 2004 2005 2006 2007 2008 2009-2011	 99.0 99.0 99.0 99.5 99.5 99.5 99.8 100.0
2.	The percent of children with special health care needs age 0 to 18 whose family's partner in decision-making at all levels and are satisfied with the services they receive. a) National Survey of Children with Special Health Care Needs (CSHCN)	2002 2003 2004 2005 2006	47.6[a] 47.6 [a] 47.6 [a] 47.6 [a] 47.6 [a]	- 2003 2004 2005 2006 2007 2008-2011	- 48.5 49.5 50.5 51.5 52.5 53.5
3.	The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. a) CSHCN Survey	2001 2002 2003 2004 2005 2006	33.4 44.7[a] 44.7[a] 44.7[a] 44.7[a] 44.7[a]	2001 2002 2003 2004 2005 2006 2007 2008 2009 2010-2011	25.0 30.0 45.5 46.5 48.0 50.0 51.0 52.0 53.0 54.0
4.	The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. a) CSHCN Survey	2001 2002 2003 2004 2005 2006	97.0 59.3 [a] 59.3 [a] 59.3 [a] 59.3 [a] 59.3 [a]	2001 2002 2003 2004 2005 2006 2007 2008-2011	97.7 98.0 60.5 62.5 64.5 66.5 68.5 70.5

* Data is either being analyzed or unavailable at the time of report

California Title V *National* Performance Measures (continued)

	National Performance Measure	*Year*	*Measure*	*Year*	*Objective*
5.	The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily. a) CSHCN Survey	2002 2003 2004 2005 2006	65.9 [a] 65.9 [a] 65.9 [a] 65.9 [a] 65.9 [a]	- 2003 2004 2005 2006 2007 2008-2011	- 67.0 68.0 69.0 70.0 71.0 72.0
6.	The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life. a) National data; sample size too small for CA, therefore no state objective at this time	2002 2003 2004 2005 2006	5.8 [a] 5.8 [a] 5.8 [a] 5.8 [a] 5.8 [a]	- 2003 2004 2005 2006 2007 2008 2009 2010 2011	- - - - - - - - - -
7.	Percent of children age 19 to 35 months who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B. a) Based on 4:3:1:3:3 series. Prior data based on 4:3:1:3 series.	2000 2001 2002 2003 2004 2005 *2006*	75.3[a] 74.9 [a] 75.8 [a] 77.4 [a] 81.3 [a] 77.9 [a] *77.9 [a]*	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011	76.0 76.4 75.4 75.8 75.8 78.0 82.0 78.4 78.9 79.4 79.9 80.4
8	The birth rate (per 1,000 females) for teenagers aged 15 through 17 years.	2000 2001 2002 2003 2004 2005 *2006*	26.6 23.8 22.4 21.1 20.6 20.3 *20.3*	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011	28.7 25.0 23.5 22.3 21.9 20.0 20.1 20.0 19.7 19.4 19.1 18.8
9.	Percent of third grade children who have received protective sealants on at least one permanent molar tooth. a) New data source based on Oral Health Needs Assessment Survey. 2003 data based on preliminary	2000 2001 2002 2003 2004 2005	18.7 19.5 19.7 31.0[a] 27.6[a] 27.6 [a]	2000 2001 2002 2003 2004 2005	19.6 18.7 19.5 19.9 20.2 31.0

	survey results.	*2006*	*27.6*[a]	2006 2007 2008 2009 2010 2011	27.6 27.6 27.6 27.6 27.6 27.6

California Title V *National* Performance Measures (continued)

	National Performance Measure	*Year*	*Measure*	*Year*	*Objective*
10	The rate of deaths to children aged 14 and younger caused by motor vehicle crashes per 100,000 children.	2000 2001 2002 2003 2004 2005 *2006*	2.9 3.1 2.9 3.6 3.1 * *	2000 2001 2002 2003 2004 2005 2006-2007 2008-2009 2010 2011	2.7 2.6 2.8 2.6 2.6 2.9 3.0 2.9 2.8 2.8
11	Percentage of mothers who breastfeed their infants at 6 months of age. (New National Performance Measure) [a] Percent of mothers breastfeeding at 2 months of age reported from the California Maternal and Infant Health Assessment (MIHA) Survey.	2004 2005 *2006*	69.1[a] 70.2[a] 70.2[a]	2004 2005 2006 2007 2008 2009 2010 2011	- - 69.6 71.0 71.5 72.0 72.5 73.0
11	~~Percentage of mothers who breastfeed their infants at hospital discharge.~~	~~1999~~ ~~2000~~ ~~2001~~ ~~2002~~ ~~2003~~	~~42.9~~ ~~42.6~~ ~~42.2~~ ~~41.8~~ ~~41.2~~	~~1999~~ ~~2000~~ ~~2001~~ ~~2002~~ ~~2003~~ ~~2004~~ ~~2005~~ ~~2006~~ ~~2007~~ ~~2008~~ ~~2009~~	~~44.0~~ ~~44.1~~ ~~44.8~~ ~~43.1~~ ~~44.0~~ ~~41.5~~ ~~41.7~~ ~~42.2~~ ~~42.7~~ ~~43.2~~ ~~43.7~~
12	Percentage of newborns that have been screened for hearing impairment before hospital discharge.	2001 2002 2003 2004 2005	21.6 52.2 56.2 68.6 75.0	2001 2002 2003 2004 2005 2006 2007 2008 2009 2010-2011	15.0 40.0 60.0 70.0 70.0 75.0 75.0 85.0 90.0 95.0

	National Performance Measure	*Year*	*Measure*	*Year*	*Objective*
13.	Percent of children without health insurance.	2000 2001 2002 2003 2004 2005 *2006*	15.7 15.3 14.3 13.1 13.1 13.6 *13.6*	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011	18.0 16.2 16.7 15.5 15.5 12.9 13.0 13.5 13.3 13.1 12.9 12.7
14.	Percent of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile. (New National Performance Measure)	2004 2005 *2006*	33.8 33.7 *33.7*	2004 2005 2006 2007 2008 2009 2010 2011	 33.7 33.6 33.6 33.5 33.5 33.4
14.	~~Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program.~~ (Moved to Health System Capacity Indicator 7A)	~~2000~~ ~~2001~~ ~~2002~~ ~~2003~~	~~60.8~~ ~~60.9~~ ~~61.7~~ ~~70.9~~	~~2000~~ ~~2001~~ ~~2002~~ ~~2003~~ ~~2004-2009~~	~~63.6~~ ~~60.3~~ ~~60.3~~ ~~59.6~~ ~~*~~
15.	Percent of women who smoke in the last three months of pregnancy. (New National Performance Measure)	2004 2005 *2006*	3.5 3.8 *3.8*	2004 2005 2006 2007 2008 2009 2010 2011	- - 3.4 3.7 3.6 3.5 3.4 3.3
15.	~~Percent of very low birth weight live births.~~	~~1999~~ ~~2000~~ ~~2001~~ ~~2002~~ ~~2003~~	~~1.1~~ ~~1.1~~ ~~1.1~~ ~~1.2~~ ~~1.2~~	~~1999~~ ~~2000~~ ~~2001~~ ~~2002~~ ~~2003~~ ~~2004-2009~~	~~1.2~~ ~~1.2~~ ~~1.2~~ ~~1.1~~ ~~1.1~~ ~~1.2~~

* Data is either being analyzed or unavailable at the time of report

California Title V *National* Performance Measures (continued)

	National Performance Measure	*Year*	*Measure*	*Year*	*Objective*
16.	The rate (per 100,000) of suicide deaths among youths 15-19.	2000 2001 2002 2003 2004 2005 *2006*	5.2 4.9 4.7 5.0 5.7 * *	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011	4.2 5.9 5.4 4.7 4.6 4.8 5.6 5.6 5.6 5.6 5.6 5.6
17.	Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.	2000 2001 2002 2003 2004 2005 *2006*	65.9 65.6 68.7 67.3 68.0 67.1 *67.1*	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011	66.4 66.5 66.6 68.7 69.6 68.5 68.2 67.2 67.5 67.8 68.1 68.4
18.	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	2000 2001 2002 2003 2004 2005 *2006*	84.5 85.4 86.5 87.3 87.1 86.6 *86.6*	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011	84.5 85.0 85.9 87.4 88.4 89.4 87.1 86.7 86.9 87.1 87.3 87.5

* Data source was unavailable at the time of report.

California Title V *State* Performance Measures

	State Performance Measures	*Year*	*Measure*	*Year*	*Objective*
1.	The percent of children birth to 21 years enrolled in the California Children Services (CCS) program who have a designated medical home.	2005 2006	57.9 76.4	2005 2006 2007 2008 2009 2010 2011	- 50.0 70.0 70.0 70.0 70.0 70.0
2.	The ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists.	2005 2006	1:491 1:541	2005 2006 2007-2009 2010-2011	- 1:491 1:540 1:500
3.	The percent of women who reported 14 or more not good mental health days in the past 30 days (frequent mental distress).	2004 2005 *2006*	13.7 12.9 *12.9*	2004 2005 2006 2007 2008 2009 2010 2011	- - 13.6 12.8 12.7 12.6 12.5 12.4
4.	The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy.	2004 2005 *2006*	16.5 17.3 *17.3*	2004 2005 2006 2007 2008 2009 2010 2011	- - 16.4 17.1 16.9 16.7 16.5 16.3
5.	The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.	2000 2001 2002 2003 2004 2005 *2006*	12.9 17.3 20.1 19.7 18.4 * *	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010	13.2 12.2 16.0 20.7 20.7 19.5 18.2 18.0 17.8 17.6 17.4
6.	The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System.	2000 2001 2002 2003 2004 2005 *2006*	7.3 5.4 7.7 7.7 5.2 6.7 *6.7*	2000 2001 2002 2003 2004 2005 2006	4.6 6.7 6.5 7.0 7.0 7.0 5.2

				2007 2008 2009 2010 2011	6.4 6.2 6.0 5.8 5.6
7.	The percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral.	2005 2006	75.7 70.4	2005 2006 2007 2008 2009 2010 2011	- 76.0 72.0 74.0 76.0 76.0 76.0
8.	The percent of births resulting from unintended pregnancy.	2004 2005 *2006*	42.4 41.3 *41.3*	2004 2005 2006 2007 2008 2009 2010 2011	- - 42.1 40.9 40.5 40.1 39.7 39.3
9.	The percent of 9th grade students who are not within the Healthy Fitness Zone for Body Composition.	2004 2005 *2006*	32.9 33.1 *33.1*	2004 2005 2006 2007 2008 2009 2010 2011	- - 32.8 32.9 32.7 32.5 32.3 32.2
10.	The percent of women 18 years or older reporting intimate partner physical, sexual, or psychological abuse in the past 12 months.	2004 2005 *2006*	9.7 8.5 *8.5*	2004 2005 2006 2007 2008 2009 2010 2011	- - 9.5 8.4 8.3 8.2 8.1 8.0

* Data is either being analyzed or unavailable at the time of report.

California Title V *National* Outcome Measures

	National Outcome Measures	*Year*	*Measure*	*Year*	*Objective*
1	The infant mortality rate per 1,000 live births.	2000 2001 2002 2003 2004 2005 *2006*	5.4 5.3 5.4 5.2 5.2 * *	2000 2001 2002 2003 2004 2005 2006-2008 2009-2010	5.3 5.2 5.2 5.4 5.4 5.2 5.1 5.0
2	The ratio of the black infant mortality rate to the white infant mortality rate.	2000 2001 2002 2003 2004 2005 *2006*	2.7 2.6 2.5 2.7 2.6 * *	2000 2001 2002 2003 2004 2005 2006-2008 2009-2010	2.6 2.7 2.6 2.4 2.4 2.6 2.5 2.4
3	The neonatal mortality rate per 1,000 live births.	2000 2001 2002 2003 2004 2005 *2006*	3.6 3.5 3.6 3.5 3.5 * *	2000 2001 2002 2003 2004 2005 2006-2007 2008-2010	3.5 3.5 3.5 3.5 3.5 3.5 3.5 3.4
4	The post neonatal mortality rate per 1,000 live births.	2000 2001 2002 2003 2004 2005 *2006*	1.7 1.8 1.8 1.7 1.7 * *	2000 2001 2002 2003 2004 2005 2006-2010	1.7 1.7 1.7 1.7 1.7 1.6 1.6
5	The Perinatal mortality rate ((deaths: fetal and infant/fetal deaths and live births) *1,000)).	2000 2001 2002 2003 2004 2005 *2006*	5.9 5.6 5.7 5.5 5.5 * *	2000 2001 2002 2003 2004 2005 2006-2008 2009-2010	8.0 7.9 5.5 5.6 5.6 5.5 5.4 5.3

California Title V *National* Outcome Measures (continued)

	National Outcome Measures	*Year*	*Measure*	*Year*	*Objective*
6	The child death rate per 100,000 children aged 1 through 14.	2000 2001 2002 2003 2004 2005 *2006*	19.2 17.9 17.8 18.8 17.2 * *	2000 2001 2002 2003 2004 2005 2006 2007-2008 2009-2010	16.4 16.9 16.2 16.2 16.0 18.4 17.2 17.0 16.8

* Data source was unavailable at the time of report.

California Title V *State* Outcome Measures

	State Outcome Measure	*Year*	*Measure*	*Year*	*Objective*
1	The maternal mortality rate per 100,000 live births.	2000 2001 2002 2003 2004 2005 *2006*	11.1 10.2 10.6 15.2 13.6 * *	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010	8.0 7.3 7.8 10.4 10.3 11.6 13.3 13.0 12.7 12.4 12.1

	Health System Capacity Indicators	*Year*	*Indicator*
1	The rate per 10,000 for asthma hospitalizations among children less than five years old.	2000 2001 2002 2003 2004 2005 *2006*	34.3 33.4 34.7 32.6 30.6 24.6 *24.6*
2	The percent of Medicaid enrollees whose age is less than one year during the reporting year that received at least one initial periodic screen.	2000 2001 2002 2003 2004 2005	66.0 70.8 66.2 67.3 66.3 73.7
3	The percent of Children's Health Insurance Program (CHIP) enrollees whose age is less than one year during the reporting year that received at least one periodic screen		NA
4	The percent of women (15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.	2000 2001 2002	76.3 76.6 77.8

			2003 2004 2005 *2006*	78.7 78.5 78.4 *78.4*
Health System Capacity Indicator 5: Medicaid and Non-Medicaid Comparison			***Year***	***Indicator***
5A.	Percent of low birth weight (<2,500 grams): Payment source from birth certificate.		2005 2005 2005	6.9(Medic) 6.8(N-Med) 6.9(All)
5B.	Infant deaths per 1,000 live births: matching data files. *2003 data are not currently available		2003 2003 2003	*(Medic) * (N-Med) * (All)
5C	Percent of pregnant women entering care in the first trimester: Payment source from birth certificate		2005 2005 2005	81.6(Medic) 90.8(N-Med) 86.6(All)
5D	Percent of women with adequate (observed to expected prenatal visits is greater or equal to 80% (Kotelchuck Index) prenatal care.		2005 2005 2005	75.4(Medic) 80.9(N-Med) 78.4(All)
Health System Capacity Indicator 6: Medicaid and CHIP Eligibility Levels			***Year***	***Indicator***
6A	The percent of poverty for eligibility in the State's Medicaid and CHIP programs for infants.	(Age 0-1)	2005	Medi: 200 / CHIP: 250
6B	The percent of poverty for eligibility in the State's Medicaid and CHIP programs for children.	(Ages 1-5) (Ages 6-19)	2005 2005	133 / 250 100 / 250
6C	The percent of poverty for eligibility in the State's Medicaid and CHIP programs for pregnant women		2005	200 / -
Health System Capacity Indicators			***Year***	***Indicator***
7A	Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program. (Previously National Performance Measure 14) a) New methodology.		2000 2001 2002 2003 2004 2005 *2006*	60.8 60.9 61.7 70.9 90.0[a] 94.7[a] *94.7[a]*
7B	The percent of EPSDT eligible children aged 6 through 9 years who have received any dental service during the year. a) New methodology.		1999 2000 2001 2002 2003 2004 2005	43.8[a] 44.6 45.5 48.1 35.5[a] 37.8[a] 44.2[a]
8	The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.		1999 2000 2001 2002	28.5 26.9 27.0 23.0[a]

	a) New methodology. b) Figures are not comparable because of another change in methodology.	2003 2004 2005 2006	22.6[a] 10.9[b] 8.7 32.5

* Data was unavailable at the time of the report.

Health Status Indicators		***Year***	***Indicator***
1A	The percent of live births weighing less than 2,500 grams	2000 2001 2002 2003 2004 2005 *2006*	6.2 6.3 6.4 6.6 6.7 6.7 6.7
1B	The percent of live singleton births weighing less than 2,500 grams	2000 2001 2002 2003 2004 2005 *2006*	4.9 4.9 5.0 5.1 5.2 5.2 5.2
2A	The percent of very low birth weight births.	2000 2001 2002 2003 2004 2005 *2006*	1.1 1.1 1.2 1.2 1.2 1.2 1.2
2B	The percent of very low birth weight singleton births.	2000 2001 2002 2003 2004 2005 *2006*	0.9 0.9 0.9 0.9 0.9 0.9 0.9
3A	The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger	2000 2001 2002 2003 2004 2005 *2006*	6.9 6.3 5.9 6.2 5.8 * *
3B	The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger	2000 2001 2002 2003 2004 2005 *2006*	2.9 3.1 2.9 3.6 3.1 * *

3C	The death rate per 100,000 due to motor vehicle crashes among youth aged 15 through 24 years.	2000 2001 2002 2003 2004 2005 *2006*	14.4 19.0 21.0 21.0 19.9 * *
4A	The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.	2000 2001 2002 2003 2004 2005 *2006*	339.3 342.8 343.9 347.0 260.8 239.0 *239.0*
Health Status Indicators		***Year***	***Indicator***
4B	The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.	2000 2001 2002 2003 2004 2005 *2006*	40.0 37.5 38.4 38.0 36.8 30.9 *30.9*
4C	The rate per 100,000 of nonfatal injuries due to vehicle crashes among youth aged 15 through 24 years.	2000 2001 2002 2003 2004 2005 *2006*	146.0 155.2 165.0 166.5 161.9 153.5 *153.5*
5A	The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia	2000 2001 2002 2003 2004 2005 *2006*	21.8 21.9 22.3 22.2 22.3 22.8 *22.8*
5B	The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.	2000 2001 2002 2003 2004 2005 *2006*	7.1 7.6 8.2 8.4 8.6 9.1 *9.1*

* Data source was unavailable at the time of report.